# STATE TITLE V BLOCK GRANT NARRATIVE
# STATE: VI
# APPLICATION YEAR: 2006

# I. GENERAL REQUIREMENTS

## A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

## B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

## C. ASSURANCES AND CERTIFICATIONS

Signed copies of the Assurances and Certifications required for this application are located at the MCH & CSHCN Program Administrative Office located on St. Thomas, VI.

These forms are available upon request by USPS Express Mail service.

## D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

## E. PUBLIC INPUT

The Virgin Islands Department of Health invites public review and input relative to planning for and writing the Title V Five-Year Block Grant Application and Program Plan for the Maternal Child Health & Children With Special Health Care Needs (MCH & CSHCN) Program. A notice is placed in local newspapers on both islands annually providing information on availability of the block grant application for public review and input. Copies of the grant application are also available upon request to agencies and partners. Response forms accompany each copy with options to accept the application as written or accept with changes and / or additions.

## II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

## III. STATE OVERVIEW

## A. OVERVIEW

III. STATE OVERVIEW
A. Overview
The Maternal and Child Health Block Grant is authorized by Title V of the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239. The Block Grant Funds assist the Virgin Islands in maintaining and strengthening its efforts to improve the health of all mothers, infants, and children, including children with special health care needs. The U.S. Virgin Islands Department of Health is the official Title V agency for the Virgin Islands.

The political status of the U.S. Virgin Islands, often called the "American Paradise", is that of an unincorporated territory. Residents are citizens of the United States. They elect the Governor, a non-voting Delegate to Congress, and a fifteen member Legislature.

Geography: The Territory of the U.S. Virgin Islands (USVI) is a collection of four major islands-St. Croix, St. Thomas, St. John, Water Island, and approximately 50 small, mostly uninhabited islands. The location of the Territory is in the Caribbean Sea at the eastern end of the Greater Antilles and the northern end of the Lesser Antilles. The Territory is 1,600 miles south southeast of New York; 1,100 miles east southeast of Miami; and 100 miles southeast of San Juan.

Of the many islands and cays comprising the U.S. Virgin Islands, only four are of economic or clinical significance at the present time. The largest, St. Croix, is 82.9 square miles, mostly flat and therefore, the most suitable for intensive economic development. It has two main towns-Christiansted, the larger of the two on the east, and Frederiksted, the smaller and more depressed on the west.

Forty miles due north, St. Thomas is approximately 32 square miles and has rugged mountains that rise sharply from the sea to heights of up to 1,500 square feet. The population density is 1,543.8 persons per square mile, more than twice that of St. Croix.

A few miles east of St. Thomas lies St. John, offering a similar land and seascape. More than half of the island is designated as a National Park, which has served to preserved much of this island's natural beauty. The main town of Cruz Bay is centrally located .

The fourth isle is Water Island, transferred from the Department of Interior on December 12, 1996. The size of the island is 2-1/2 miles long and 2 miles wide with an area of 500 acres. Water Island is separated from St. Thomas by 2 mile and is close enough to draw life support from.

Population: According to the 2003 USVI Community Survey, the population of the Virgin Islands was 110,740 persons: 54,277 on St. Croix, and 56,463 on St. Thomas/St. John. This is a 2% increase from the 2000 U.S. Census population of 108,612. The 2003 USVI Community Survey data estimated males represented 47% or 52,146 and females 53% or 58,594. The median age of respondents was 36.4 years.
Table 1 below shows children and youth 0 -19 years representing 32.9% of the population or 36,058. The following categories were reported:

| Age Group | 2003 | Percent | 2000 | Percent |
|---|---|---|---|---|
| Under 5 years | 8,188 | 7.4 | 8,553 | 7.9 |
| 5-9 years | 9,144 | 8.3 | 10,176 | 9.4 |
| 10-14 years | 10,232 | 9.3 | 9,676 | 8.9 |
| 15 -- 19 years | 8,494 | 7.6 | 6,688 | 8.0 |

Table 1: USVI Population less than 19 years
Source: 2003 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands; 2000 USVI Population Census , US Census Bureau.

The total population represents a 6.9% increase during the period 1990-2003. The decrease in the number of children under age 5 from 1990 to 2003 accounts for over half of the overall decline in the

population under 18. Tables 1-A and 1-B show comparison data from this period.
Category 1990 2003 Increase/Decrease Percent Change
Total 101,809 110,740 +8,931 +8.1%
< Age 5 9,230 8,188 -1,042 -.94%
Ages 5-19 29,837 27,870 -1,967 -1.7%
Ages 20-59 53,083 58,469 +5,386 +4.8%
Ages 60+ 9,659 16,214 +6,555 +5.9%
Table 1-A: 2000 USVI Census total population by age:
Source: 2003 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands; 2000 USVI Population Census , US Census Bureau.

Category 1990 2003
Under Age 5 9% 7.3%
Ages 5-19 29% 25.2%
Ages 20-59 52% 52.7%
Ages 60+ 10% 14.6%
Table 1- B: Population by Percentage
Source: 2003 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands; 2000 USVI Population Census , US Census Bureau.

Ethnic Composition: The entire USVI population consists of persons who are predominantly of African descent, Black or African-American. While St. Thomas has the highest percentage of people of African descent, St. Croix has the highest percentage of Hispanics, whose place of origin may be other Spanish-speaking islands, such as Puerto Rico of the Dominican Republic. The 2000 Census estimated the racial composition of the V.I. population as Black/African American 76.2%, Whites 13.1 %, Other races 7.2% and Two or more races 3.5%. (Table 2)
Population Number Percent
Black / African American 82,750 76.2
White 14,218 13.1
Other races (2) 7,852 7.2
Two or more races 3,792 3.5
Table 2: 2000 USVI Census Population by Race

The 2003 USVI Community Survey shows a parallel slight increase in the Black / African American (1.1%) and decrease in White populations (2.5%). There was a slight increase (1.4%) reported in other races. Table 2-A shows a comparison for the three year period.
Population Number Percent
Black / African American 85,637 77.3
White 11,700 10.6
Other races 13,403 12.1
Table 2-A: 2003 USVI Population by Race
Source: 2003 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands.

The 2000 Census estimated 93,416 persons of non-Hispanic origin and 15,196 persons of Hispanic origin (Table 3). The majority of Hispanic residents reside on St. Croix with an estimated population of 11,277.
Population Number Percent
Hispanic or Latino -Total 15,196 14.0
Puerto Rican 8,558 7.0
Mexican 308 0.3
Cuban 141 0.1
Other Hispanic or Latino 6,189 5.7
Table 3: 2000 USVI Census by Hispanic or Latino origin

In contrast, the 2003 USVI Community Survey estimated 92,011 persons of non-Hispanic origin and

18,729 persons of Hispanic origin. Table 3-A demonstrates the increase in this population (2.9%).

| Population | Number | Percent |
|---|---|---|
| Hispanic or Latino -Total | 18,729 | 16.9 |
| Puerto Rican | 11,442 | 10.3 |
| Dominican Republic | 5,222 | 4.7 |
| Cuban | 152 | 0.14 |
| Other Spanish | 1,912 | 1.7 |

Table 3-A: 2003 USVI Community Survey Population by Hispanic Origin
Source: 2003 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands.

The Virgin Islands is a multicultural society. The 2000 US Census shows approximately 66.8 % of the population was born in the V.I. and 33.2 % born outside of the territory. In 1995, approximately 50.5% of the population was born in the V.I. and 49.5% were born outside of the Territory according to the 1995 Population and Household Survey.

| Nativity | Number | Percent |
|---|---|---|
| Total Native/U.S. born | 72,525 | 66.8 |
| Foreign born | 36,087 | 33.2 |
| Naturalized citizen | 23,080 | 21.2 |
| Not a citizen | 13,007 | 12.0 |

Table 4: 2000 USVI Census Population by Nativity/Citizenship

Table 4 shows 21.2% are naturalized citizens, of which 3% entered from 1990 to 2000 and 18.2% entered before 1990. Many of the persons who migrated to the territory seeking employment have now established citizenship here.
However, 2003 data shows a decrease in the population born in the Virgin Islands (52,224 or 47%) and other U.S. born outside the territory (16, 693 or 15%). Table 4-A shows a comparison for the period 2000-2003 by place of birth. Concurrently, there is a 3.5% increase in the number of naturalized citizens and slight increase (0.5%) in non-U.S. citizens who are permanent residents.

| Nativity | Number | Percent |
|---|---|---|
| Total Native/U.S. born | 68,917 | 62.2 |
| Other Caribbean | 38,037 | 34.3 |
| Other Foreign born | 3,786 | 3.4 |
| Naturalized citizen | 27,354 | 24.7 |
| Not a citizen | 13,925 | 12.5 |

Table 4-A 2003 Population by Place of Birth.
Source: 2003 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands.

Per Capita Income: In 2002, the per capita income in households in the Virgin Islands was $14,370 St. John had the highest per capita income of $19,394, followed by St. Thomas at $11,77 6 and St. Croix's at $9,402. In 2001, per capita income in households was $13,885. Per capita income in households on St. John remained highest at $17,282, followed by St. Thomas at $14,318 and St. Croix at $13,197.
Source: V.I. Bureau of Economic Research

Poverty Status: Based on 1995 V.I. Population and Household Survey, 20.6% of families had incomes in 1994 below poverty levels. Poverty levels increased in 1999 for families to 28.7%. For individuals, 32.5% had incomes below poverty. Though poverty levels decreased for families, in 2001 child poverty in the Virgin Islands continues to be high with a rate of 36.5%. Children living on St. Croix have a significantly higher rate of poverty rate at 45%, when compared to St. Thomas at 31%. Children on St. John have a lower rate of poverty at 10.5%. The national child poverty rate in 2001 was 16%. The 2002 poverty level for families was reported at 22.2%. For individuals or persons, the poverty level was reported at 25.6%
Source: USVI Kids Count Data Book 2003, Community Foundation of the Virgin Islands.

Table 5 shows a comparison of families below poverty level based on income earned for years 1999 and 2002.

| Population | Number below poverty level | | Percent below poverty level | |
|---|---|---|---|---|
| | 1999 | 2002 | 1999 | 2002 |
| Families | 7,635 | 9,611 | 28.7 | 23.1 |
| Families with related children under 18 years | 5,862 | 6,262 | 35.3 | 17.2 |
| Families with related children under 5 years | 2,637 | --- | 41.0 | --- |
| 5-17 years | 5,212 | | 15.0 | |
| Families, no husband present | 4,521 | 4,917 | 44.6 | 14.9 |
| Individuals | 34,931 | 37,950 | 32.5 | 34.2 |

Table 5: Income comparison 1999 and 2002 of families below poverty level.
Source: 2003 Virgin Islands Community Survey, Eastern Caribbean Center, University of the Virgin Islands, Poverty Status in 2002 (families); 2000 USVI Census Poverty Status in 1999 (families).

Cost of Living Indicators: Studies have shown that the cost of living in the Territory is about 30% higher than Washington, D.C., the place with which the Territory is usually compared. The Virgin Islands inflation rate currently is about 3.1 percent.

Educational Attainment: Table 6 shows that of the 65,603 persons 25 years and over 60.6% were high school graduates or higher and 16.7% received a bachelor degree or higher. Individuals with less than a ninth grade education represented 18.5%, and persons who received a ninth to twelve grade education but no diploma represented 20.9%.

| Educational attainment | Number | Percent |
|---|---|---|
| 25 years and over | 65,603 | 100 |
| Less than 9th grade | 12,133 | 18.5 |
| 9th to 12th grade, no diploma | 13,743 | 20.9 |
| High school graduate includes equivalency | 17,044 | 26.0 |
| Some college, no degree | 9,425 | 14.4 |
| Associate degree | 2,269 | 3.5 |
| Bachelor's degree | 6,841 | 10.4 |
| Graduate or professional degree | 4,148 | 6.3 |

Table 6: 2000 USVI Census Educational Attainment

Public and non-public school enrollment as of 2000 is 25,620, a decrease in 2,955 or 10% in the last 10 years. This represents 90% of the total number of children of school age. In the Virgin Islands there is a very high number of teen-agers who drop out of school -- 17% - data indicating this usually happens in the first year of high school. The majority of drop outs are male (53%). It is estimated not surprisingly, that approximately 12.6% of youth not in school are also unemployed. There is only one institution of higher learning in the Virgin Islands, the University of the Virgin Islands, which has a campus on St. Croix and St. Thomas. There is some indication that persons are beginning to access on-line education through the internet; however, data is not available at this time on amount or impact.

(Source: DHS Community Assessment 2003)

Language: English is the only spoken language at home for 74.4% of the population 5 years and over. A language other than English (Spanish, French, Indo-European language and Asian/Pacific Island languages) is spoken by 25.3% of the population 5 years and over (Table 7).

| Population | Number | Percent |
|---|---|---|
| 5 years and over | 100,059 | 100 |
| English only | 74,740 | 74.7 |
| Language other than English | 25,319 | 25.3 |

Table 7: 2000 USVI Census Spoken Language

Marital Status: Table 8 shows that of 42,649 females 15 years and over, 40% have never married. Similarly, 40.1% of the men 15 years and over have never married.

| Females | Number | Percent |
|---|---|---|
| Never married | 17,092 | 40.1 |
| Married | 15,400 | 36.1 |
| Separated | 1,519 | 3.6 |
| Widowed | 3,147 | 7.4 |
| Divorced | 5,481 | 12.9 |

Table 8: 2000 USVI Census Marital Status of Women

Special Needs: Table 9 shows disability of persons (five years and over) such as: severe hearing, vision impairment; substantial limitation in their ability to perform basic physical activities; difficulty learning, remembering or concentrating, difficulty in performing activities of daily living, persons sixteen years and over are considered to have a disability if they have difficulty going outside the home alone to shop or visit a doctor's office.

| Population | Number | Percent |
|---|---|---|
| 5 -- 20 years | 29,697 | 100 |
| With a disability | 1,402 | 4.7 |
| 21-64 years | 60,632 | 100 |
| With a disability | 11,371 | 18.8 |
| 65 and over | 8,947 | 100 |
| With a disability | 3,424 | 38.3 |

Table 9: 2000 USVI Census Disability status of the non-institutionalized Population

Local Area Unemployment: St. Croix's economy is primarily based on manufacturing. Major industries include Hovensa Oil Corporation, V.I. Rum Industries, watch factories and several pharmaceutical companies. St. Thomas' economy is largely based on tourism and the retail industry. There was some weakening in the performance of the U.S. Virgin Islands economy during 2002 reflecting the general downturn in the US economy after September 11, 2001. There was negative growth in the tourism and hospitality sector and in manufacturing. The major sectors (construction, wholesale and retail trade, finance insurance, real estate and transportation), showed some marginal improvement over 2001, but was too soft to effect overall economic growth.

Performance over the past year (2004) showed improvement in some sectors of the economy. The US economic expansion, gains from federal tax cuts, and lower interest rates resulted in increased tourism and business and financial activity. The strong performance of these two sectors helped to support growth and bolstered government revenues. However, the gains from tourist and local consumer spending, business activity, and mortgage refinancing were not strong enough to offset the drag from declines in the construction, trade, transportation and utilities, professional and business, information and other services sectors. Although the economy is improving, job growth remained stagnant and nonexistent. The labor market remained in a slump and ended fiscal year 2003 with a net loss of 1,570 jobs. Employment fell in every sector, except the financial activities, leisure and hospitality, and education and health sectors. The construction sector, a primary driver of employment growth over the past two years, lost the majority of jobs due to the completion of major private sector capital projects. Personal income spurred by tax cuts and lower mortgage rates sustained the economy last year. Growth in personal income was estimated at 2 percent. Despite a 3.6 percent drop in nonagricultural wage and salary jobs, the economy improved on the strength of consumer spending.

Job growth remained elusive for the first half of fiscal year 2004, and only a modest improvement was expected for the remaining months of the fiscal year. However, the economy is expected to experience a more balanced expansion in fiscal year 2005, given the continued expansion of the US economy, and planned and ongoing capital investment projects. Underlying the expectations for growth are the beliefs that federal monetary and fiscal stimulus will continue, and business investment will continue to exhibit strong growth. Proposed changes to tighten the residency requirement for economic development incentive benefits have potential to disrupt the financial services sector which

is a strong performer adding over $100 million to the VI economy. Over the next year, the Virgin Islands economic performance will be largely tied to the economic health of the national economy as well as to local economic development initiatives. The outlook for 2005 projects increases in the leisure and tourism industry, financial services and construction sector supported by major hotel and casino construction, upgrade and expansion of roads, housing and seaports, development of commercial and residential properties and Hovensa's desulfurization unit.
The territory's unemployment rate for the first quarter of fiscal year 2004 decreased by 1.6% from fiscal year 2003 . The rate for St. Croix decreased to 11.1% from 12.9% the previous year.
Total non-agricultural employment averaged 3.6% less, decreasing to 41,833 jobs from 43,406 jobs in the corresponding period in fiscal year 2003.
Government /public sector employment declined about 1% with 11,503 jobs from 12,545 the previous year. Federal employment showed no major changes with 912 jobs down slightly from 919 in fiscal year 2003. Local government jobs are expected to continue to decline in fiscal year 2005 as part of the government's cost cutting initiatives through attrition, retirement and elimination of vacant positions.
Second to government, the service industry employs the most V.I. workers. An upturn in the tourism and hospitality industry, specifically in hotel accommodations, has improved this sector's performance. The sector is expected to grow during the next fiscal year as demand grows in travel and tourist related industries. This sector includes hotels, business, legal, educational, auto and miscellaneous repair services.
Total private sector employment accounted for 70% of the territory's jobs. Average employment in this sector fell by 1.9% for the first six months of fiscal year 2004 to 28,959 jobs from 29,526 during the same period in fiscal year 2003.
Trade -- both retail and wholesale- accounted for 28% of all employed. The number of jobs in trade showed no improvement during the first six months of fiscal year 2004. Employment levels are expected to be flat for the remainder of fiscal year 2004, but may improve in 2005 as the economy expands and spending grows.
The construction sector had an average of 1,737 jobs in fiscal year 2003 and 1,660 in the first half of fiscal year 2004 down from 3,182 in fiscal year 2002. As capital projects neared or reached completion jobs in this sector disappeared. Permit value a leading indicator of growth, increased 82.8% in the first quarter of fiscal year 2004. Lower interest rates helped to fuel the strong growth in private residential and non-residential values.
Finance, Insurance, and Real Estate accounts for 4% of the territory's employment, This sector showed strong growth in fiscal year 2003 and employed 2,304 or 16% more jobs fiscal year 2002. Growth continued for the first half of fiscal year 2004 with an average of 2,395 jobs and is expected to improve in fiscal year 2005.
Manufacturing which accounts for 5% of nonagricultural jobs, which averaged 2,038 for the first half of fiscal year 2004, up slightly from 2,023 for the same period in fiscal year 2003. Transportation, communications and public utilities remained stable for 2003 and account for 6% of all employment. Jobs in the sector were decreased by 1.2% for the first six months of fiscal year 2004 when compared to the same period in 2003 and employment is likely to remain stable for the remainder of 2004 and is expected to improve in 2005.
Source: USVI Bureau of Economic Research, May 2004

General labor force trends: According to the Bureau of Labor Statistics the labor force fell to 48,460 in fiscal year 2003 from 49,346 in fiscal year 2002. For the first half of fiscal year 2004, the labor force averaged 47,582. Civilian employment declined 1.2 percent for the first half of fiscal year 2004, down to 43,415 from 44,062 for the same period in fiscal year 2003. The territorial civilian unemployment rate which averaged 9.5% in fiscal year 2003, decreased to 8.8 percent in fiscal year 2004.

Mass Transit System: : The Virgin Islands Transportation (VITRAN) mass transit system became operational in FY95. VITRAN provides transportation between remote locales, the main towns, and along the major thoroughfares. Buses are equipped and available to provide transportation for individuals with disabilities who require use of wheelchairs or other assistive devices. Major cutbacks in the scheduling and operation of these buses limits the service available to the public. Private taxi services are frequently utilized as the primary mode of transportation.

Environment: A unique factor, which affects the territory's infrastructure, is the increased incidence of powerful hurricanes, which have struck the territory in the past decade and a half. In 1989, the devastating Hugo struck St. Croix and destroyed 95% of the homes. In 1995, Hurricane Marilyn, a powerful category III hurricane, struck St. Thomas. On St. Thomas, 92% of the homes were damaged (habitable) or destroyed (inhabitable); on St. Croix and St. John, 71% and 86%, respectively of housing units were affected (Source: MMWR Vol.45/No.4). In 1997, Hurricane Georges, a category II hurricane, caused additional infrastructure damage. . During this period the Federal Emergency Management Agency (FEMA) offered millions of dollars to aide in the islands' recovery . In addition, the tourist industry suffered a loss of millions of dollars. In November 1999, Hurricane Lenny- category II- passed south of St. Croix and caused additional damage to buildings and the infrastructureWhile there were no major storms in the past two years, the territory and its residents continue to experience the economic impact of high insurance rates.

In-migration: There is in-migration of undocumented residents from neighboring Caribbean islands. Based on geographic proximity to British possessions of Tortola, British Virgin Islands, and the island of Hispaniola-Santo Domingo and Haiti, immigrants come to deliver in the Virgin Islands in order to ensure U.S. citizenship for their offspring. They are uninsured and ineligible for any formal government programs. Most of the pregnant women present without records of prenatal care. In complicated pregnancies, critical newborns are cared for at the expense of the local hospitals and ultimately the Government of the Virgin Islands. Communication difficulties are also encountered. Actual numbers for undocumented residents are unavailable and estimates vary due to lack of data from reliable and knowledgeable sources. Additionally, this population is considered itinerant and constantly changing. They generally live in certain geographic areas, are non-English speaking, and access the health care system only when necessary. Language differences presented a challenge for effective communication.

Welfare Reform: In the Virgin Islands, the programs affected by changes in the Personal Responsibility and Work Act are: Public Assistance, Food Stamp Program, Child Care and Development Block Grant, and Job Opportunities and Basic Skill Program (JOBS). The specific changes occurring in these programs are: 1) Persons receiving cash awards under the Aid to Families With Dependent Children (now called Temporary Assistance to Needy Families-TANF) have lifetime benefits for a five year period only; 2) Immigrants must have paid in 40 quarters of social security, individually or combined with a spouse, before they can receive benefits, unless they are in a special exemption category outlined in the Law; 3) Any one between the ages of 18-50 years, who are able bodied without dependents and are not engaged in work or some work activity, can only receive Food Stamps for a period of three months in a three-year period; 4) Under the appropriations portion of Title IV Child Care, Section 418 (d), the U.S. Virgin Islands has been determined ineligible to receive an allotment from new Mandatory and Matching child care funds; 5) As a result of work requirement for recipients for TANF, referrals to the JOBS Program will increase significantly. Additional activities required will be short-term training programs and jobs.
The Department of Human Services summarizes the impact of Welfare Reform as follows:
-A reduction in the number of persons receiving Food Stamps, resulting in the number of stamps issues and impacting the economy overall.
-The work requirement for families with children will increase the cost of childcare significantly and funding in this area is extremely limited.

Temporary Assistance to Needy Families State Plan became effective July 1, 1997. Changes affecting Food Stamp recipients who are able bodied became effective November, 1996. The immigrant policy became effective for Food Stamp recipients on April 1, 1997 for persons already receiving assistance. New applicants to the program were affected by the original date of enactment, August 22, 1996.
The Department of Human Services annual report for fiscal year 2004 shows a total of 2,260 persons who were recipients of assistance through various income maintenance programs -- 1,210 adults and 1,050 children. TANF recipients numbered 351 adults (93 or 26% from St. Thomas/St. John; 258 or 78% on St. Croix); and 1,025 children ( 285 of 28% from St. Thomas/St. John; and 740 or 72% from

St. Croix). It is significant to note that in July of FY 2002, the five year life-time benefits expired for those recipients of TANF from its inception. This has had a major impact on St. Croix where employment opportunities are limited. A temporary assistance program was initiated using local funding to assist those clients on St. Croix who are in training or apprenticeship programs. In the last five years, there has been a 59% decrease in TANF recipients. From FY 2003, there has been a significant increase in adults receiving general assistance up by 65%.

The Agricultural Research, Extension and Education Reform Act of 1998 (AREERA), Public Law 105-185, changes some of alien eligibility provisions and broadens alien eligibility to make more aliens eligible for Food Stamp benefits.
The Farm Security and Rural Investment Act of 2003 (Public Law 107-171), commonly referred to as the 2003 Farm Bill, restores food stamp eligibility to many legal immigrants who lost eligibility under the 1996 Welfare Reform legislation. The effective date for qualified legal immigrants who have been in the country for five years to regain eligibility was April 1, 2003. A small number of disabled immigrants has their eligibility restored prior to that date.
The Food Stamp Program is one of the territory's major prevention programs for low-income families. Additionally, when a disaster is declared, the Food Stamp program, upon approval of the US Department of Agriculture Food and Nutrition Services regional office administers the Disaster Food Stamp Program. This program provides one-time food stamp support to families who have suffered loss due to disaster. In addition, the program, while not considered a revenue generating program brings into the territory $19 million per year. This not only helps in the prevention of poor nutrition but supports local grocery stores by increasing revenue and jobs which in turn increase money circulation within the community. In FY 2004 4,532 households received allotments monthly, 1,566 on St. Thomas/St. John or 35%; and 2,966 on St. Croix or 65%.
The Welfare Reform Act of 1996 mandated all states and territories to implement Electronic Benefit Transfer (EBT) systems before October 1, 2003. The EBT system provides electronic access to food stamp benefits through clients' use of a magnetic stripe card.
The Temporary Assistance to Needy Families (TANF) continues to operate under the Welfare Reform regulations.
The Department continues to partner with the Departments of Labor, Health, Education, Housing and the University of the Virgin Islands in meeting the needs of TANF recipients. //2004//
(Source: Department of Human Services Annual Report 2004)

Movements Towards Managed Care: Health Maintenance Organizations (HMOs) do not exist in the Virgin Islands. Medicaid managed care is also non-existent in the territory. The Government of the Virgin Islands, as the largest employer offers health insurance coverage to its employees. Health insurance fees and increased costs of government health insurance continue to be a barrier for low-income families. In June 2001, the Government of the Virgin Islands renegotiated the contact for health insurance, which resulted in increased premiums to the employees. The insurance coverage reimburses at a 80/20 ratio for care received in the territory, and 60/40 for services received outside of the territory. Government employees are required to participate in the government group insurance plan.

## B. AGENCY CAPACITY

III - B. STATE AGENCY CAPACITY
Statutory Authority: The Virgin Islands Department of Health is designated as the agency in the Virgin Islands for administering the Maternal and Child Health and Children With Special Health Care Needs Program (MCH & CSHCN) pursuant to Title 19, Chapter 7, Section 151 of the Virgin Islands Code.

The Virgin Islands Department of Health's Maternal and Child Health & Children With Special Health Care Needs (MCH & CSHCN) Program activities are directed at improving and maintaining the health status of women, infants, children, including children with special health care needs and adolescents. The MCH & CSHCN Program is the cornerstone for family and comprehensive health service systems.

Vision statement: The US Virgin Islands Department of Health envisions an effective health care system that will increase the territory's wellness by educating and mobilizing the communities toward the development of positive lifestyles.

Mission: The Virgin Islands Department of Health is the territorial authority committed to:
•Provide quality health care
•Regulate, monitor and enforce health standards to protect the public's health
•Educating, mobilizing, and empowering the community toward the development of positive lifestyles and
•Protecting the health and safety of the community.

Values:
• Dedication to the public good
• Caring customer service
• Excellence in job performance
• Efficient teamwork
• Respect for self, clients, and co-workers
• Integrity and confidentiality

Goals: The five major performance goals guiding the department encompass all legal mandates as spelled out in the V.I. Code. These goals also address the focus areas for achieving the department's mission.
• Improve health outcomes and access to quality health care
• Provide health education, health promotion and community-based programs
• Enhance mental health and substance abuse services
• Achieve excellence in management practices
• Enforce laws and implement rules and regulations

The mission of the MCH & CSHCN Program is to promote and improve the health of women, children, adolescents and families, including those with special health care needs; and assure access to quality health care services for high-risk and special needs groups through planning and coordination of comprehensive health services systems.

Goals & Objectives: MCH & CSHCN goals are: (a) to assure access to comprehensive coordinated, family-centered, culturally-competent primary and preventive health care services for all women and children, especially low income and vulnerable populations, in order to promote and improve pregnancy and birth outcomes; (b) to improve the health of children and adolescents including those with special health care needs through comprehensive, coordinated, family-centered, culturally-competent primary and preventive care; and (c) to provide a system that eliminates barriers and health disparities and strengthens the MCH infrastructure.
The goal of the Prenatal/Perinatal Program is to prevent maternal and infant deaths and other adverse perinatal outcomes by promoting preconceptual health, assuring early entry into prenatal care, and improving perinatal care.

Program Capacity: The Title V MCH & CSHCN Program is administered as one integrated program within the Department of Health. This allows for better and more efficient coordination of services in MCH. The program provides health care services for mothers, infants, children, youth and adolescents and their families. The program also provides and coordinates a system of preventive and primary health care services for this population. These services include prenatal and high-risk prenatal care clinics, postpartum care, well child care, high risk infant and pediatric clinics, care coordination and access to pediatric sub-specialty care for children and adolescents with special health care needs.
For children, ages 0-21, with disabilities and chronic conditions, the program provides preventive and primary care, therapeutic and rehabilitative services. The MCH & CSHCN program offers a system of family-centered, coordinated, community-based, culturally competent care, assuring access to child

health services including medical care, case management and home visiting, screening, referrals and assistance obtaining a medical home. Services are provided either directly through Title V or by referral to other agencies and programs that have the capability to provide medical, social, and support services to this population. Public Health Nurses provide parental counseling and education regarding growth and developmental milestones, proper nutrition practices, immunizations; service/care coordination and home visiting services to high risk children and their families.
Clients with acute illnesses or who require medical procedures beyond the capability of the medical staff to provide are referred to the Emergency Department for assessment and treatment.
Residents of the territory are not eligible for the Supplemental Security Income (SSI) Program which provides assistive devices, therapeutic or rehabilitative services beyond acute care to children under the age of 16 with disabilities. The Medical Assistance Program does not provide these services, due to the Medicaid Cap imposed by Congress. These services are provided on a limited case by case basis by the Title V Program when required.
Nursery referrals are received on all high-risk newborns who are followed in the MCH & CSHCN clinics. Infants without any high-risk factors are referred to well child clinics. Infants classified as high-risk or at-risk for a disability due to biological, physiological, or environmental factors or diagnosed with medical conditions are followed in the Infant High Risk clinics. High-risk referral patients are screened to receive a home visit, and family assessment. Screening is conducted by Infants and Toddlers' (Part C of IDEA) service coordinator in order to identify newborns as part of the Infants and Toddlers (Part C) Child-Find system.
Public health nurses assess the developmental needs of infants and toddlers who are at-risk due to psychosocial or biological risk factors.

The Charles Harwood Complex is the principal site for MCH service delivery on St. Croix. All clinic staff and services returned to the Charles Harwood Complex during September and October 2004 at the completion of renovations which started in 2002. This complex has been modernized to a state of the art, one stop health facility. This complex houses approximately three hundred employees representing several programs and divisions.

Clinics include: Prenatal Intake for new patients in which the history, physical, risk assessment, PAP smear, and laboratory referrals are done; Midwife Clinic or Revisit Clinic for routine follow-up and counseling; Teen Prenatal and Family Planning Clinics; and Perinatal/High Risk Clinic for the management of obstetrically or medically complex cases. Patients with emergencies are referred to the Obstetrical Ward for evaluation and treatment. In-patient deliveries are performed by the hospital's Obstetricians and Midwives.

Diagnostic services, such as ultrasounds and laboratory services, are available at the hospitals or at private facilities. The government does not operate a public health laboratory on either island outside of the hospital facilities.

On St. Croix, prenatal care capacity consists of one Nurse Midwife (vacant), one Obstetrician (.1FTE), and a Territorial Perinatologist (.1FTE) at the MCH Clinic. The Obstetrician/Gynecologist performs the initial medical evaluation, manages medically complicated patients, and provides limited gynecological services. The program is actively recruiting a Certified Nurse-Midwife and OB-GYN Nurse Practitioner for St. Croix through the Bureau of Health Professions/National Health Service Corps, as this island is designated as an underserved area by HRSA. However, salaries and compensation are not comparable to the U.S. mainland creating challenges to filling these positions.
On St. Thomas, prenatal services are administered by the Community Health Clinics with one Midwife, one Nurse Practitioner, an Obstetrician, (vacant) and Perinatologist (.1FTE). The Perinatologist also serves as the Director of Women's Health and conducts clinics at East End Health Center, Frederiksted Health Center, and at the Morris F. deCastro Clinic on St. John. The St. Thomas/St. John district did not meet the minimum score to be designated as an underserved area. However, the Bureau of Health Professions does allow for individuals eligible for Loan Repayment to be recruited and employed.

Patients are referred to the WIC or Community Health Nutritionists for dietary assessments,

counseling, and follow-up. Dental services are provided at Charles Harwood, on St. Croix, and the Governor Roy Lester Schneider Hospital, on St. Thomas, and are operated under the auspices of the Division of Dental Health Services. Social workers assist patients with assessments and applying for Medicaid and other services.

Health services are offered through a system, which employs a variety of health care professionals to include Pediatricians, Nurses, Pediatric Nurse Specialist, Clinical Care Coordinators, Social Workers, Dentists, and Dental Hygienists. Allied health professionals may serve territorially when necessary. As of March 2004, there are 177 physicians licensed to practice in the territory. This includes eighteen (18) Obstetricians, fifteen (15) Pediatricians and twenty-nine (29) General/Family Practitioners. (Source: V.I. Board of Medical Licensure, 2004).

The three main facilities for primary care services are MCH & CSHCN Clinics, PHS 330-Community Health Centers, and hospital-based Community Health Clinics. On St. Thomas MCH's principal facility is located in the western district, the Community Health Clinics at the Governor Roy Lester Schneider Hospital serve the mid-island district, and the East End Health Center is located in the east district. On St. Croix, the Frederiksted Health Center is located on the western end of the island, and the MCH & CSHCN principal facility is located in the east at Charles Harwood Complex. On Cruz Bay,St. John, the Morris DeCastro Clinic is the site for the MCH & CSHCN monthly Infant/Pediatric high-risk clinic.

Through a series of outreach activities, the MCH & CSHCN Unit identifies children who have health problems requiring intervention, are suffering from disabling, or chronic medical conditions, or are at risk. A system of public health nursing, based on specified health districts, is an integral component of providing family-centered, community health services. Sources of child-find include referrals from the Queen Louise Home for Children, Early Childhood Education, Head Start, and Private Providers. Pediatricians, Nurses, Social Workers, a Physical Therapist Assistant, an Occupational Therapist, Audiologist, and Speech Pathologist are the major providers of direct services. The Infants and Toddlers Program employs Service Coordinators on each island.

Hospital newborns with biological, established, or environmental risks are referred to the Infant or Pediatric High Risk clinics based on established criteria. At one year of age, infants are re-assessed and transition to the Well Child Clinic or the Pediatric High Risk Clinic. The Infant and Pediatric High Risk Clinics offer comprehensive, coordinated, family-centered services. Screening is done for developmental delay using the Denver Developmental Screening Tool. Social Workers complete an assessment of the family and home environment, existing support structures, and financial status. A diagnostic assessment and therapeutic plan is developed by the clinical staff. Through an appointment system, children with special health care needs are referred to the sub-specialty clinics by the primary care physician. The Physical Therapist serves territorially. The Speech Pathologist on St. Thomas may travel to St. Croix to provide services and conduct screening.

Population-Based Services: The MCH & CSHCN Program offers three population-based preventive services: immunization services; the newborn genetic / metabolic screening program; and the newborn hearing screening program. Each is discussed under related Performance Measures. Funding awarded from the Centers for Disease Control and Prevention for a four-year Cooperative Agreement starting September 1, 2001, enabled continuation of newborn hearing screening under the auspices of the MCH & CSHCN Newborn Screening and Follow-up Program. The Infants & Toddlers Program continues as the primary referral source for children identified with hearing loss/impairment requiring amplification or habilitative services. This CDC funding ends on August 31, 2005. These services will continue under the auspices of the Title V Block Grant. Significant improvement in newborn hearing screening rates before hospital discharge since the inception of the program was noted. See discussion under Performance Measure #12.

Direct Care/Enabling Services: Specialty clinics provide pediatric specialty services that are generally unavailable or inaccessible to low-income, uninsured or underinsured families. Cardiology clinics provide assessment and evaluation of heart disease and provide medical treatment and management. Hematology clinics provide evaluations and family education for children with sickle cell

disease, hemoglobinopathies, and follow-up for other hematological disorders such as leukemia, ITP, etc. Orthopedic clinics provide specialized exams, diagnostic procedures, and intervention recommendations for conditions such as scoliosis, and other orthopedic conditions. Other clinics such as Pulmonology and Neurology are also available. The specialty services are offered to all children in the territory irregardless of ability or inability to pay.
Translation services at clinics are available through bilingual staff for Hispanic-Spanish speaking clients and French-dialects from the eastern Caribbean islands. Transportation services are not routinely offered but can be arranged with the administrative office. Off-island air transportation may be provided based on need and availability of funds. Home visitation is conducted on a priority basis for high-risk populations. Nutrition services are offered by Women, Infant and Children's Program (WIC), and the Community Nutrition Program.

There was a noticeable, though not documented, increase in the number of uninsured children of undocumented families who have not met the residency or other legal requirements to apply for medical assistance, or who would not otherwise receive health care, seeking health care and sub-specialty health care through the program. Provision and delivery of these services enabled high risk populations to establish relationships with the health care system.

Infrastructure building services: The program continued activities directed at assuring the availability of the infrastructure necessary to delivery of services to the maternal/child population and to increase access to quality health care for families who lack sufficient financial resources to meet the costs of medical care. Access to staff development activities, training and technical assistance to assure continuous quality of care was provided. Improvement in data collection activities for monitoring and evaluation of services to this population was undertaken during this fiscal year. Challenges remain with a lack of adequate data linkages and child health information systems to support program activities including data collection and analysis. Program policy and procedures manual is revised to address the need for standards and guidelines for service provision, data collection, training and quality assurance/improvement.

## C. ORGANIZATIONAL STRUCTURE

III - C. ORGANIZATONAL STRUCTURE

The MCH & CSHCN Program is a unit within the Department of Health, one of 14 government departments. The Department of Health is headed by the Commissioner of Health. The Department of Health was reorganized in July 1999. The executive staff consists of the Commissioner of Health, Administrator for Policy and Program Planning, Deputy Commissioners for Divisions of Public Health Services, Fiscal Affairs, Administrative Services and Management and Health Promotion and Disease Prevention.
The Department of Health's mission is to provide quality health care, regulate, monitor and enforce health standards to protect the public's health. This is achieved by open communication with the public, informing them of health care options, thus serving as a catalyst to assist them in making educated choices on receiving the highest quality of health care. The agency is committed to building a sound policy and program infrastructure that reflects the twenty-first century. The Department is the sole state agency responsible for coordinating and providing a focal point for territory wide public health efforts on behalf of Virgin Islanders and visitors to the territory.

The MCH & CSHCN Program reports directly to the Deputy Commissioner for Public Health Services. The Program is operated as a single organizational unit and serves as both local and state agency. This single State agency is authorized to administer Title V funds and is responsible for both Maternal and Child Health and Special Needs Children Services. The Administrative Unit is composed of the Director for MCH & CSHCN, Program Administrator St. Croix, Fiscal Officer, St. Croix and Office Manager, St. Thomas.

The MCH & CSHCN Program is guided by an advisory council, a thirty (30)-member body charged

with the responsibility of advising the Administrative Unit of the MCH & CSHCN Program. The Advisory Council assists in developing goals and objectives, long range program planning, identifying service gaps, locating resources, and monitoring the quality of services provided. Members of the Council include representatives from: Family Planning, Departments of Education, Human Services and Justice, Infants and Toddlers, 330-funded health centers, parents and guardians of children with special health care needs, child care providers, hospitals and faith and community-based organizations. The MCH Director, Program Administrators and SSDI Administrator are ex-officio members. The Advisory Council was revitalized in 2003 with the election of a dynamic chairperson who played a major leadership role in revision of the By-Laws of the Council. Several committees were formed to address issues and challenges within the program including program evaluation, quality improvement, public awareness and family participation. Members of the council also served on the adhoc committee for the five-year needs assessment. The Council was instrumental in review of the Block Grant narrative and provided valuable input.

Hospitals: There are two public hospitals, the Governor Juan F. Luis Hospital on St. Croix, and the Roy Lester Schneider Hospital on St. Thomas. The hospitals are under the management of a Territorial Board and two District Boards established under Bill No. 20-0366, "The Virgin Islands Government Hospitals and Health Facilities Corporation Act", in 1994. The Commissioner of Health serves as a non-voting, ex-officio Board of Directors member.

In 1999, Bill No. 20-0030 granted partial autonomy to the hospitals. The Chief Executive Officer has the power to appoint the Medical Director, Chief Financial Officer, managerial personnel, health providers, and other professional and non-professional personnel. The bill further granted fiscal autonomy by establishing a Hospital and Health Facilities Fund for the purpose of receiving, managing, and disposing of monies or property on behalf of the V.I. Government Hospitals and Health Facilities Corporation. The Commissioner of Health remains with the legal authority to issue a certificate of need and license hospital facilities.

Both hospitals were built at 250-bed capacity. A Level II nursery exists on St. Thomas, headed by a Neonatologist. In 1999, a Neonatologist joined the staff of the Governor Juan F. Luis Hospital. /2002/ Infants on St. Croix are no longer transferred to St. Thomas for Intensive Neonatal Care. Newborn patients requiring neurosurgery or cardiac surgery may be transferred to Puerto Rico or Florida.
In June 2001, the Governor Juan F. Luis Hospital received accreditation from the Joint Commission on Accreditation of Hospital Organizations (JCAHO) for a three year period. Full reaccreditation was received in 2004 for an additional three year period.
The Governor Roy Lester Schneider Hospital on St. Thomas received accreditation from the Joint Commission on Accreditation of Hospital Organizations (JCAHO) for a three year period in December 2003.

330-Funded Community Health Centers: The Frederiksted Health Center, (FHC), serves approximately 25,000 on the western side of St. Croix. Adjacent to FHC is the Ingeborg Nesbitt Urgent Care Center (INC), which provides walk-in services to patients of all ages. Critical patients are transferred to the Governor Juan F. Luis Hospital and Medical Center. Laboratory services and pharmaceutical services are provided on site. FHC services include: Family Practice, Family Planning, Prenatal, Pediatrics, Women's Health, Social Services, and Immunizations. The St. Thomas East End Medical Center (STEEMC), on St. Thomas, serves the medically under-served population on the heavily populated eastern end of the island. Services include general primary medical care, diagnostic, laboratory, and referral for diagnostic x-ray procedures, family planning, HIV testing, and immunizations. OB-GYN care includes gynecological care, prenatal care, antepartum fetal assessment, referral for ultrasounds, genetic counseling and testing, and postpartum care. Dental care services include preventive, restorative, and emergency.

An affiliate agreement has been signed by the Governor of the Virgin Islands, placing the governance of the health centers under the authority of the governing boards. The health centers were incorporated as not-for-profit entities. Policies regarding fiscal and personnel issues are being finalized. By June 2005, it is anticipated that both 330 centers will be private corporations independent

of the Department of Health. An Office of Primary Care has been established to coordinate Primary Care services within the Office of the Governor. A Territorial Primary Care Plan is being developed.

Myrah Keating Smith Health Center: Located on St. John, this center serves as an ambulatory facility. In 1999, management of this facility was turned over to the Governor Roy L. Schneider Hospital and the Hospital's Board.

Community Health Clinics: The St. Thomas Community Health Clinic is located at the Governor Roy Lester Schneider Community Hospital. This clinic provides prenatal, gynecology, family planning services, and pediatric services. On St. Croix, the Community Health Clinic is located at the Charles Harwood Complex. Services include eye clinics, diabetic clinic and primary care for adults. This activity center screens, diagnoses and treats patients with medical problems such as diabetes, hypertension, cardiovascular disease and arthritis. Sub-specialty clinics which provide services in neurology, urology, podiatry, orthopedics, minor surgery, wound management and allergic/dermatologic disease are conducted. An Epidemiology Committee meets quarterly to discuss issues or concerns related to bio-terrorism activities and emerging/infectious disease that may impact the territory including SARS and Anthrax, and collect data of epidemiological impact.

Emergency Medical Services: The Emergency Medical Services (EMS) is the agency charged with the provision of pre-hospital emergency medical care. Inter-island patient transfer services between St. Croix and St. Thomas and Puerto Rico or the continental United States are privately arranged. This agency is responsible for management of the ambulance system, and participates in the delivery of emergency care within the hospital emergency department and the Health Department clinics. Training is provided for all levels of EMT's including Pediatric Advanced Life Support (PALS), and Advanced Cardiac Life Support (ACLS), Emergency Vehicles Operators Course (EVOC), and basic cardiac life support courses for the public.
The MCH & CSHCN program was awarded an EMS-C grant for a three year period, March 2003-February 2006, in partnership with the Division of Emergency Medical Services (EMS) to improve and increase preparedness activities to address pediatric emergencies including natural disasters, bioterrorism and mass casualty occurrences that incorporates components for pediatric needs. The purpose of this funding is to develop and implement a sustainable Emergency Medical Services-Children (EMS-C) system to strengthen the existing capability to provide pediatric emergency services. The goal is to ultimately reduce morbidity and mortality from severe illness or trauma by improving the quality of pediatric emergency medical care and supporting injury prevention. By the end of the project period in February 2006, the EMSC program is anticipated to be fully integrated into the Division of EMS.

An enhanced 9-1-1 telephone system has been implemented, allowing the dialing of a single series of numbers to request Police, Fire, or Emergency Medical Services. These calls are received at a single location, and then transferred to the respective agency. Pursuant to Act No. 6333 passed by the Legislature and approved by the Governor on December 2, 1999, effective April 1, 2000 a $1.00 emergency service surcharge is added to all residential and commercial telephone bills. These collections are placed in a special fund, the "Emergency Services Special Fund", to be used by the Commissioner of Health, the Commissioner of Police, and the Director of Fire Services for the purchase of equipment or supplies necessary to provide, maintain, and improve emergency medical services, fire services and 911 emergency equipment.

Bioterrorism: The Department of Health (DOH) is the lead agency responsible for coordinating the Public Health response in the case of a biological attack. The mission of the Bioterrorism Program is to prepare the public health and hospital infrastructure to handle threats to the community's health. Through systems of biological, chemical, and laboratory surveillance, coupled with communication and alert systems the U. S. Virgin Islands will be able to track and respond to potential threats on the populations' health. The vision of the program is to create a state of the art system in which public health and hospitals have the ability to respond to identified threats before they become a public health threat. Funding is received from the Centers for Disease Control and Preventionfor Public Health Preparedness & Response to Bioterrorism, and Health Resource Services Administration for

Hospital Bioterrorism Program.

## D. OTHER MCH CAPACITY

III - D. OTHER CAPACITY

Role of the Parents: Parents have played a vital role in the program planning and evaluation, quantitatively, and qualitatively. Parents are involved in preliminary planning and implementation of each program. Parent representatives were part of the core committee, which developed the client survey instrument for the five year needs assessment, and were hired to conduct interviews. There are parent representatives on the MCH Advisory Council and the V.I. Interagency Coordinating Council. Parents participate in off-island training, which involves improving the quality of services being provided to infants and children with and without special health care needs.

Health Planning: The Office of Health Planning is charged with the responsibility of reviewing all grant applications submitted by the MCH & CSHCN Program to ensure consistency with departmental objectives. This position remained vacant throughout fiscal year 2004.

Vital Records and Statistics: Vital Records and Statistics collect, analyzes and disseminates vital events data in the territory. The program works with the courts, healthcare facilities, the University of the Virgin Islands and other agencies involved in births, deaths, marriages and divorces. Its mission is the registration of births, deaths, and other vital statistics in the territory.
This office generates the health statistics, leading causes of death and maintains a cancer registry for the Virgin Islands. Due to technical and managerial personnel shortages, this office remains limited in it's capacity to analyze data. A Director was appointed for this office in 2003. Full computerization of the Vital Registry system is still not realized after several years of efforts the electronic vital registry system is not implemented.

Office of Grants Writing and Program Analysis: The Office of Grants Writing and Program Analysis was established in 1999 to incorporate monitoring, and program evaluation. That office is charged with the responsibility for locating appropriate grants, provide assistance in preparation of and reviews grants applications, and monitors any conditions or terms applied to the grant. The office also ensures that the intergovernmental review process is conducted when applicable. The position is currently vacant, although efforts at recruitment continues.

Office of Management Information Systems and Communication Services: This office, (formerly OCCS) is responsible for evaluating and recommending hardware and software for the various programs/divisions. Responsibilities include: installation, maintenance, training and ongoing support of all computer and communication systems. Additional functions include research and development of new applications for technological advancements, which can reduce costs while improving efficiency. The goal of MIS is to automate all programs/divisions within a comprehensive network for electronic data sharing and telephone interconnects via a technologically advanced communication network. Internet access, E-Mail, data sharing, and an Integrated Health Information System for all clinics The goal of MIS is to automate all programs/divisions within a comprehensive network for electronic data sharing and telephone interconnects via a technologically advanced communication network. Internet access, E-mail, data sharing, and an Integrated Health Information System for all clinics are provided through this network. The network is anticipated to be linked into the government-wide computer environment for e-mail, processing personnel requests through the Department of Personnel, and access to the Financial Management System.

## E. STATE AGENCY COORDINATION

## III - E. STATE AGENCY COORDINATION

The MCH & CSHCN Unit plays a leadership role in developing a comprehensive system of service. Agency and community resources include Human Services, Developmental and Disabilities Council, Department of Justice (Office for Paternity & Child Support), Department of Education, Special Education/Early Childhood Program, Head Start Program, and Disabilities and Rehabilitation Services. The V.I. Advocacy Agency, Inc. and Legal Services provide an effective voice for persons with disabilities. Representatives of these agencies serve on the MCH & CSHCN Advisory Council, V.I. Interagency Coordinating Council, Community Integrated Service System, and the V.I. Alliance for Primary Care. They participate in planning and evaluating services for children with special health care needs.

Infant & Toddlers Program: The Early Intervention Program for Infants and Toddlers with Disabilities was established under Public Law (PL) 99-457. The Department of Health is the lead agency and administers this grant via the Infants & Toddlers Program which supplements the MCH & CSHCN Program, when public or private resources are otherwise unavailable, by providing early intervention services such as: service coordination, physical therapy, speech and language therapy, occupational therapy, vision therapy, special instruction, and family training. The Infants & Toddlers Program is a territory-wide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers (age birth through three), with disabilities and or developmental delays, and their families. The goal is to enhance the capacity of families to meet the special needs of their children. The program is supported by its Interagency Coordinating Council (ICC) whose membership includes parents of children with disabilities and or developmental delays, public and private sector service providers, and various other stakeholders. The Infants & Toddlers Program's collaborative efforts with and close physical proximity to the Maternal Child Health and Children with Special Health Care Needs Program (MCH & CSHCN) Program are especially effective as shown above via its Child Find activities.

V.I. Interagency Coordinating Council: : The V.I. Interagency Coordinating Council (VIICC) is charged with the task of advising and assisting the Department of Health in the implementation of the Individuals with Disabilities Education Act. The VIICC includes representatives of state public agencies, such as the Department of Health, MCH & CSHCN, Department of Human Services, Department of Education, Special Education/Early Childhood Education, Univeristy of the Virgin Islands, public and private providers, advocacy agencies, parents of children with disabilities, and the V.I. Legislature. An Interagency Memorandum of Understanding with the Departments of Health, Human Services, and Education coordinates the early intervention services for children under three years. This agreement is to be revisited to include children 0 -- 5 years.

Head Start Screening: A revision of the existing formal agreement between the Department of Human Services and Department of Health is currently in progress. The revised document reflects the role of the MCH & CSHCN Program in providing Speech and Audiometric/Hearing screening and referrals for follow-up specialty care

Mental Health Services: Pursuant to Title III, Section 418, of the Virgin Islands Code the Department of Health is designated as the single State agency for mental health, alcoholism and drug dependency. The division is organized into six (6) areas: prevention, assessment, intake, and evaluation; outreach, case management, and rehabilitation; crisis intervention; outpatient mental health & substance abuse and residential services. Major focus on the development of a community-based system of care began with the Child and Adolescent Service System Program (CASSP) Demonstration Grant. Achievements include the development of the V.I. definition of Severely Emotionally Disturbed (SED) children and adolescents. Mental health services to children include evaluation, assessment, and therapy. Services are provided by a psychologist and therapist, with consultation from the Department's Psychiatrist.
The Division of Mental Health Outpatient clinic on St. Croix reported a significant increase in referrals from schools, clinics, parents and private physicians for children with conduct and learning disorders which include ADD, ADHD and autism. There is a noticeable shift with more children and adolescents

referred for services than adults. More than 50% of children followed are on medications for these disorders and require frequent and close monitoring. Services are provided in the least restricted environment and are available and accessible to all who need them. Service planning and delivery is client based and includes the participation of children and their families, with treatment based on family preservation when possible. Children and adolescents with SED needing multi-agency services will receive them in a coordinated fashion.

Developmental Disabilities: The Developmental Disabilities Program is authorized under Public Law 94-103, the Developmental Disabilities Assistance and Bill of Rights Act of 1973. In the Virgin Islands, the Department of Human Services administers the Developmental Disabilities Program through its developmental services component. The developmental services component provides grants to public and private non-profit organizations. Services provided through these grants include legal advocacy, employment, training, and special transportation. The Developmental Disabilities Council advises the Department of Human Services in the performance of these functions.

VI University Center for Excellence in Developmental Disabilities (VIUCEDD), formerly VI University Affiliated Program, was established in October 1994 and is funded by the US Department of Health and Human Services, Administration on Developmental Disabilities and the US Department of Education, Office of National Institute on Disability and Rehabilitation Research. The unique nature of working with young children implies that professionals develop the skills necessary for working with and collaborating effectively with families and other professionals. A broad knowledge of development and learning across the birth through eight age range is necessary for educators to provide appropriate curriculum and assessment approaches. The fact that not all children develop at the same rate and children with developmental delays and disabilities are included in typical early childhood classes requires that professionals have knowledge of an even wider range of development and learning. The VIUCEDD mission is to enhance the quality of life for individuals with disabilities and their families and to provide them with tools necessary for independence, productivity and full inclusion into community life. This is accomplished by providing a continuum of educational opportunities through which the student in Inclusive Early Childhood Education may earn a Certificate, an Associate of Arts Degree, and a Bachelor of Arts Degree. VIUCEDD also offers American Sign Language courses during the fall and Spring semesters, and technical assistance to community groups serving individuals with disabilities

Vocational Rehabilitation Program: The Vocational Rehabilitation Program is authorized by the Rehabilitation Act of 1973, Public Law 93-112 and its amendments. The program is administered by the Department of Human Services. The program offers services to eligible individuals with disabilities in preparation for competitive employment including: supportive employment through Work-Able, a non-profit placement agency; independent living services; provision of a vending stand program for visually impaired individuals; and in-service training programs for staff development.
Summary of Service Delivery: Disabilities & Rehabilitation Services
Basic Grant: Under this grant, vocational rehabilitation services conducts assessments for determining eligibility, provide counseling, guidance, and referral, physical and mental restoration services, coordinates vocational and college activities and on-the-job training and transportation for individuals with disabilities. Additionally, it coordinates and funds support services which include: interpreter services for individuals who are deaf, reader services for individuals who are blind, services to assist students with disabilities transition from school to work, personal assistance services, rehabilitative technical services and devices, supported employment and job placement services. The average age of individuals receiving services was 20 years with 56% female and 44% male. Data on race and ethnicity is not available. In fiscal year 2004, the program provided services: on-going monitoring and support to 338 clients; placed 25 new persons in jobs.
Statistical trends showed client totals in 2002 (524), 2003 (457), and 2004 (338). Of that total, females equaled 42%(2002), 43%(2003), and 56%(2004). While, males 58%, 57%, and 44%. The average age ranged from 20 to 32 of clients receiving these services. (Source: DHS Annual Report FY 2004)

Women, Infants and Children Program: The Special Supplemental Nutrition Program for Women, Infants, and Children, (WIC), is authorized by Public Law 95-927, as amended. The Virgin Islands

WIC Program is 100% federally funded and is administered by the Department of Health. The purpose of WIC is to serve as an adjunct to preventative health care services during critical times of growth and development, in order to promote and maintain the health and well being of nutritionally at-risk women, infants and young children. Persons eligible for the program include pregnant, breastfeeding and postpartum women, infants and children up to age five who are determined by a health professional to be at nutritional risk and meet income criteria. WIC promotes breastfeeding as the optimal infant feeding choice unless contraindicated.

The VI WIC Program remains dedicated to provide family-centered nutrition education and services to WIC participants/caretakers in order that optimal growth and development of infants and children occur, and to assist in prenatal, postpartum and breastfeeding women making informed health and dietary choices for themselves and their families. An 86% breast-feeding rate among WIC post-partum participants was maintained. See discussion under NPM #11.

Family Planning Program: Family Planning is authorized by Section X of the Social Security Act. The V.I. Family Planning Program was initiated in 1979 to support the provision of voluntary services primarily to low income persons. The mission of the Family Planning Program is: "To promote optimal health in our community, in the full understanding of the culture, habits and needs of our community, by assisting and counseling individuals, mainly women of childbearing age, and families to achieve the goals they have set for family size; by promoting healthy sexual attitudes and behavior, and by improving adolescents understanding and attitudes about human sexuality and contraception". The program provides: medical evaluations, human sexuality and contraceptive counseling, infertility management, genetic counseling, and social, nutrition, and health education referrals.
The Family Planning Program's accomplishments were related to it's mission to provide affordable, culturally sensitive educational, counseling and comprehensive medical and social services necessary to enable individuals, mainly women of childbearing age, to freely determine the number and spacing of their children, help reduce maternal and infant mortality and promote the health of mothers and children.

V.I. Perinatal Inc.: V.I. Perinatal Partnership's Healthy Start funding ended during this fiscal year. The program reorganized as V. I. Perinatal, Inc., a non-profit 501(c) (3) organization. Program staff applied for and received funding from the HRSA "Healthy Community Access Program" entitled: "Promoting Healthy Families" Initiative, PHFI, to increase access of uninsured and low-income families into the public insurance program; increase of the target population to a family-centered, comprehensive, coordinated system of care; and to reduce the rate of pre-term births, diabetes, hypertension and cancer in the target populaton Program efforts are designed to improve the health of women of reproductive age and their newborns by assuring that comprehensive, quality maternal health care services, including outreach, case management and education, are available and accessible. VIPI continues to focus on increasing consumer presence to achieve broader consumer representation; identifying and enrolling clients most in need of perinatal services and implementing strategies to reduce infant mortality and morbidity on St. Croix. The program received local funding to expand services to the St. Thomas -- St. John district in Fiscal Year 2005-2006. See discussion under NPM # 15 & 18 The MCH & CSHCN Director is the Title V representative on VIPI's Executive Board.

State Systems Development Initiative, ( SSDI ) grant is focused on the Title V MCH Block Grant Health Systems Capacity Indicator #9(A) which is addressed through seven project objectives:1) improve access to data linkages between birth records and Medicaid files; 2)create data linkages between birth records and WIC eligibility files; 3)obtain access to hospital discharge data; 4 )increase analyses of data from the Youth Risk Behavior Survey(YRBS); 5)monitor opportunities for establishment or improvement in priority data linkages and access to priority data sets that are unable to be addressed in the current project period;and 6)provide quality data for MCH Block Grant performance measures and five-year needs assessment. To date the goals of this indicator are not realized due to technical and staffing challenges within the DOH system. SSDI funds will be utilized for for collecting, analyzing, presenting and interpreting much of the data needed for the five year MCH Block Grant needs assessment

Abstinence Education Program: The Adolescent Health Program ("AHP") is designed to provide services to the adolescent and young adult populations, whether through direct delivery, or by referral, comprehensive and routine emergency physical and mental health services and intervention in response to a demonstrated need. To date the most effective arm of the AHP is the Abstinence "Only" Education Project (i.e., "SEXUAL ABSTINENCE: A Healthy Choice") under the aegis of the MCH/CSHCN Program, Department of Health ("DOH") in accordance with New Section 510, Title V of the Social Security Act, MCH Block Grant, Public Law 104-193. The Abstinence Education Program in the Virgin Islands is administered by the Adolescent Health Program under the auspices of the Community Health Service within the V.I. Department of Health. The Adolescent Health Director is responsible for coordination the program. The goal of the program is to offer "sexual abstinence" as a healthy choice in the prevention of pregnancy and sexually transmitted diseases and to attract and facilitate the adolescent population, person's ages 13-19 years, in making the decision to become or remain "sexually abstinent". The abstinence education curriculum is to be promoted through the assistance of community-based agencies. The future of this program within the structure of DOH is uncertain for Fiscal Year 2005 and 2006. Abstinence Education funding was placed under the Administration for Children and Families by Presidential order. It remains to be determined which agency, Department of Health or Human Services AE will be operated under.

Medicaid Program: Medicaid is authorized under Title XIX of the Social Security Act of 1935, as amended by P. L. 89-97 and is administered at the federal level by the Health Care Financing Administration. In the Virgin Islands, Medicaid is administered by the Department of Health, the designated single State agency. The Virgin Islands State Plan for Medical Assistance was approved by the Department of Health and Human Services (formerly Health, Education and Welfare) and has been in operation since 1966.
The mission of the Medical Assistance Program is to assure that health care is readily available and accessible to all eligible low income persons and that the care is of high quality, is comprehensive and continuous. To fulfill this mission, the Program must: assure that clients have access to necessary medical care; assure that the quality of care meets standards; promote appropriate use of services by clients; promote appropriate care by service providers; and assure that services are purchased in the most cost-effective manner.

The V.I. Medicaid Program is the central source of health care for the Virgin Islands' most vulnerable residents: the aged, blind, disabled individuals and low income families who cannot afford to pay for their own health care expenses. As the payor of last resort, the MCH & CSHCN Program is fiscally linked to the Medical Assistance Program. The Medical Assistance Program (MAP) functions under a $6,080,000 (cap) for fiscal year 2002 and a ratio of Federal and Local matching of 50/50. Mandatory Medicaid services include inpatient hospital, outpatient hospital, health clinic services, laboratory & x-ray services, Early & Periodic Screening, Diagnosis & Treatment (EPSDT), Family Planning, nursing home and physician services that must be pre-authorized, and Dental services. Optional services (but covered) include: optometrist services, eyeglasses, prescribed drugs, air transportation, and respiratory therapy. Optional services (not covered) include: services in institutions for mental illness, hospital transfer/air ambulance transportation, dentures prosthetic devices, physical and occupational therapy, and/or durable equipment.

A revised Statement of Agreement to Ensure Maximum Collaboration and Utilization of the MCH & CSHCN Program under the Virgin Islands State Plan for Medical Assistance has been executed by the Commissioner of Health and the Program Directors for MCH & CSHCN and MAP. This collaborative agreement provides for the coordination of care and services available to low-income populations served under Title V and Title XIX. . This agreement was last revised in Fiscal Year 1999-2000. Efforts will continue in FY 2006 to revisit and update based on current identified needs. Assistance in applying for Medicaid is provided to users of Title V services through social workers at the MCH & CSHCN facilities. Social workers inform clients of all documents required at the time of registration, i.e. birth certificates, passports, naturalization papers, etc. In addition, information is provided about location of MAP offices, hours of operation, and how patients should apply for Medicaid. Potentially eligible MAP patients are identified at various sites including outpatient ambulatory facilities, hospital facilities, and other government agencies such as the Department of

Human Services. Patients who are low-income, uninsured, pregnant, or have special health care needs are referred to Social Services or the MAP offices directly for eligibility determination.

Child Health Insurance Program: Title XXI of the Social Security Act was enacted August, 1997 and provides 24 billion dollars over five years to insure millions of American children in families at or below 200% of of poverty for children not eligible for Medicaid or other public or private insurance. The Title XXI legislation appropriated .25% of the total FY98 budget for all territories amounting to $10,687,500, of which 2.6% was appropriated for the Virgin Islands. The Child Health Insurance Program, CHIP, is administered by the Bureau of Health Insurance and Medical Assistance. The Child Health Insurance Program Plan, which has been approved by the Centers for Medicare and Medicaid (CMS), allows for payment of unpaid medical bills for Medicaid patients less than 19 years of age. This waiver was allowed by CMS because Congress did not approve enough CHIP monies for the territories that would have allowed them to have a regular Child Health Insurance Program. In FY2004, the CHIP allotment was $1,629,435. These limited funds were used to pay already incurred medical bills for Medicaid children whose federal Medicaid funding ran out by the end of the year. Because many states were unable to spend their CHIP allotments, the unspent monies were redistributed which benefited the territories. However, a full fledged CHIP program is not established in the Virgin Islands due to lack of appropriate funding.

## F. HEALTH SYSTEMS CAPACITY INDICATORS

III-F. SUMMARY - HEALTH SYSTEMS CAPACITY INDICATORS

01 - The rate of children hospitalized for asthma (10,000 children less than five years old).
Data required to complete this measure was received from both hospitals, Roy L. Schneider Hospital on St. Thomas, and Juan F. Luis Hospital on St. Croix for fiscal year 2004, and includes Emergency Department visits and in-patient admissions. 83 children in this population were admitted to the ED on St. Thomas with 22 of those admitted to the Pediatrics Unit. Average length of stay was 2.4 days according to the data received. Similar admissions were noted on St. Croix with 85 ED visits and 27 in-patient admissions. The average length of stay was 2.5 days. The number of in-patient admissions and average hospital stays clearly demonstrate the need for development and implementation of both a territory-wide asthma plan and an asthma surveillance system. A major component of this plan would identify strategies for promoting proper outpatient management of asthma and decreasing inappropriate hospitalizations.

02 -The percent of Medicaid enrollees whose age is less than one year who received at least one periodic screen.
The Early Periodic Screening, Diagnostic and Treatment (EPSDT) program provides well-child and comprehensive pediatric care for children and adolescents through age 20. Medicaid data systems in the territory lack the capability to provide specific data relating to periodic screening in this section. This data is not available from the Medicaid program. The MCH & CSHCN Program lacks access to the paid claims files.

03 - The percent of State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.
This HSCI is not applicable to the V.I. due to the Medicaid Cap. The Child Health Insurance Program, CHIP, is administered by the Bureau of Health Insurance and Medical Assistance. The Child Health Insurance Program Plan, which has been approved by the Centers for Medicare and Medicaid (CMS), allows for payment of unpaid medical bills for Medicaid patients less than 19 years of age. This waiver was allowed by CMS because Congress did not approve enough Child Health Insurance Program (CHIP) monies for the territories that would have allowed them to have a regular Child Health Insurance Program.

04 - The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent of the Kotelchuck Index.
The information to report on this indicator is not available from the Office of Vital Records despite

several written inquiries.

05 - Comparison of health capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.
A recent study on insurance was undertaken by the University of the Virgin Islands, Eastern Caribbean Center for the Bureau of Economic Research. This study found that the rate of uninsurance in the VI is 24.1%. This estimate is 7% higher that the rate for the entire US. 21% of the VI population was uninsured for the entire year. This is 9% higher than the equivalent measure for the entire US population. The average expenditure for MAP in the VI in 2000 was $436 per person compared to the US national average of $3,862. This disparity in resources critically impacts upon availability and accessibility of health care for low income families.

06 - The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0-1), children, Medicaid and pregnant women.
Due to the federal Medicaid cap which severely restricts provision of services to all eligible families, eligibility is determined at 200% of poverty level.
The federal Medicaid cap remains in place. There are no indications that Congress will change or increase this in the near future.

07 - The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.
The Division of Dental Health Services continued to provide oral health care services, examinations and preventive services for the MCH population on a daily basis.
The School Outreach Program -- 2003/2004 school year for grades Kindergarten, Fifth and Ninth received dental screenings and topical fluoride applied. A total of 2,256 students were treated. On St. Croix, 1469 students received treatment and on St. Thomas/St. John 787 students were treated. Data is not collected by age, insurance type or race/ethnicity. The number of EPSDT eligible children is not known. Sealants were not provided to any age group due to lack of supplies.

08 - The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services for the State CSHCN Program.
This HSCI is not applicable to the V.I. SSI benefits are not available to children with disabilities. Rehabilitative services are provided through the Department of Education Special Education Program and the MCH & CSHCN Program.

09(A)- The ability of States to assure that the Maternal and Child Health Program and Title V Agency have access to policy and program relevant information.
The MCH & CSHCN Program has the ability to access data via written request for program planning or policy purposes. Linkages with electronic databases that house the data are not yet available.

09(B)- The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products.
The USVI High School Youth Tobacco Survey was conducted during school year 2003-2004. A total of 1,054 students in grades 9-12 participated in the survey. 30.7 % had ever smoked (Male=31.4%, Female=30.2%); 7.2% currently use any form of tobacco; 3.1% smoke cigarettes; 1% use smokeless tobacco. 60.8% want to stop smoking, 44.5% tried to stop smoking during the past year, and 9.9% have ever received help to stop smoking.

09(C) - The ability of states to determine the percent of children who are obese or overweight.
The DOH Bureau of Public Health Nutrition remained without a Nutritionist during this fiscal year. Since current trends show that obesity, especially childhood obesity, has emerged as a national health problem, the VI-WIC program focused on obesity this year,. Elements from Fit-WIC Virginia and Vermont were selected to be included in developing a VI WIC obesity initiative entitled, "Watch That Portion, Weight Modification Initiative". Progress with the initiative includes the development of: Seven (7) goal sheets with suggestions to meet the goal in the following areas: reading labels, increasing fruits, increasing vegetables, eating less sugar, eating less fat, increasing exercise,

controlling calories. The VI WIC Program Information Systems contractor made the necessary changes to the data system, enabling data required for participation in the Centers for Disease Control PedNSS. This information is specific to the WIC population.

# IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

## A. BACKGROUND AND OVERVIEW

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES
ANNUAL REPORT / ANNUAL PLAN

A. Background and Overview

The Title V Maternal and Child Health Services Block Grant Program is operated as a single Administrative Unit within the Department of Health. The unit, headed by the Assistant Director of MCH & CSHCN, is responsible for conducting the statewide assessment of needs, agency management, program planning and implementation, policy development, and interagency collaboration. Within the Administrative Unit are Program Administrators on each island who supervise the financial and clinic management, and program activities.
In FY '04, MCH & CSHCN administered the following programs:
• Preventive and Primary Child Health Care
• Integrated newborn genetic/metabolic and hearing Screening
• Prenatal Care Services and Care Coordination
• Subspecialty Care Services

The FY 2004 central focus was promoting territorial leadership in assuring the public's health and safety for all women, children, youth, adolescents, and children with special health care needs. Mirroring the national leadership of the Maternal & Child Health Bureau, vis a vis the MCHB Strategic Plan, local efforts supported the implementation of the program plan developed in response to the needs assessment. The Maternal Child Health Bureau's goals are to eliminate barriers and health disparities, and assure access to quality care, and improve the health care infrastructure. The Maternal and Child Health Bureau put forth national values, which formed the platform for framing local action within the states and territories:
• Affordable and accessible high quality care for all.
• Accountable, regularly monitored and evaluated evidence-based quality care.
• Preventive, protective health care that address individual's physical, psychological, and social needs.
• Comprehensive, coordinated care in medical homes that includes direct and enabling services.
• Consumer-oriented, family-centered and culturally-competent care linked to community services.
• Continually improving health care based on research, evaluation, training/education, technical assistance, and the dissemination of up-to-date information.

Throughout FY'04, the MCH & CSHCN Program employed strategies to promote care coordination and collaboration among programs serving the special needs population. Outreach, education and case management activities for pregnant women were provided through the expanded V.I. Perinatal Perinatal Inc., (Promoting Healthy Families-HCAP and Healthy Families, Healthy Babies Initiative). Collaboration is on-going with the Department of Human Services in the development and implementation of the Child-Care Guidelines, a V.I. Stepping Stone Manual, Rules and Regulations for Child Care in the Virgin Islands. MCH staff were trained as child care health consultants. Partners and collaborators who were actively engaged with the program to maximize sharing of resources included individuals from the Departments of Education, Labor, Justice, 330 funded Community Health Centers, Medical Assistance Program, WIC Program, Vital Statistics, Immunization, Dental Health, Family Planning, Nursing Services, Adolescent Health Abstinence Education Program, Social Services, STD/HIV/TB, Infants and Toddlers Program, Community Partners, and Parent Advocates. Parent and consumer participation and involvement via the V. I. Alliance for Primary Care and the MCH Advisory Council were strengthened.

## B. STATE PRIORITIES

IV-B. State Priorities
The Virgin Islands MCH & CSHCN has identified the following top ten (10) priority needs for primary

and preventive care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for children with special health care needs.
•To improve access to prenatal care and reproductive health services.
•To increase healthy births
•To increase certification and enrollment in family support programs.
•To increase linkage of special needs children with needed health and community-based support services.
•To assure adherence to good nutrition standards.
•To improve access to primary and preventative health care services for all segments of the MCH population.
•To improve early childhood development while reducing child abuse.
•To promote community partnerships.
•To increase genetic risk awareness.
•To promote responsible sexual behavior.

These identified needs are related to specific performance measures addressed by the program and are addressed on the four levels of the MCH pyramid.

Issues related to access to care are addressed through provision of comprehensive primary and preventive care for children and adolescents which includes access to direct medical care; referrals to support programs and services; and strengthening of Title V collaborative partnerships. The Title V program continues to function as the safety net for families with limited resources. The program remains committed to providing clinical preventive care services for pregnant women, infants and children in low income populations.
Children with special health care needs have access to a source of care that provides evaluation and treatment sources; early developmental and hearing screening; early intervention services; care coordination and family support services, and access to clinical and laboratory services.
Improvements in data systems for collection, analysis, surveillance and reporting capacity are critical to providing accurate assessments to assure these needs are met and the target population is being served.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 96 | 96 | 97 | 98 | 99 |
| Annual Indicator | 94.8 | 98.5 | 98.3 | 98.7 | 96.9 |
| Numerator | 1595 | 1753 | 1669 | 1589 | 1619 |
| Denominator | 1682 | 1780 | 1698 | 1610 | 1670 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 99 | 99 | 99 | 99 | 99 |

## a. Last Year's Accomplishments

All babies born in community hospitals are screened for seven genetic disorders: sickle cell hemoglobinopathies, galactosemia, hypothyroidism, maple syrup urine disease, homocystinuria, G6PD, and phenylketonuria (PKU). Patients and families with positive results receive genetic counseling, case management and comprehensive care within 2 months of diagnosis.
96.9 percent of newborns received genetic / metabolic screening in calendar year 2004 with three (3) children identified with sickle cell disease and two (2) with hypothyroidism.
Howard University Biochemical Genetics Laboratory continues to provide newborn genetic/metabolic screening on a contractual basis.
A Hematology Clinic meets monthly and offers sub-specialty consultation with a board-certified pediatric hematologist. The clinic is integrated within the primary care pediatric clinics. These services are provided on both St. Thomas and St. Croix.
The newborn screening database is now fully integrated to include hearing screening.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
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## b. Current Activities

A decrease in hospitalizations and complications has occurred in this special needs population. There were no deaths during this fiscal year. One hundred percent of newborns confirmed with sickle cell disease receive an initial pediatric hematology evaluation by four months of age and are entered into a comprehensive system of care.
During calendar year 2004, three infants were diagnosed with sickle cell or other hemoglobin variant disease. 100% are enrolled in comprehensive care and receive prophylactic penicillin. Their families received education and counseling on disease management. The program continues to strive to achieve 100% of screening territory-wide. For CY ‘04, 96.9 % of newborns in the territory were screened.

## c. Plan for the Coming Year

All babies born in the territory will continue to be screened. Those identified as positive will receive comprehensive diagnostic and confirmatory testing.

Parent information brochure on newborn screening was revised to reflect 4th grade literacy levels and is awaiting translation into Spanish and French Creole for dissemination in prenatal and post-partum settings.
Patients and families with positive results will receive access to genetic counseling, case management and comprehensive care. Sub-specialty consultation with a board-certified pediatric hematologist will continue to be available. Parent support groups on each island will continue.
Howard University Biochemical Genetics Laboratory will continue to provide newborn genetic/metabolic screening on a contractual basis.
The integrated newborn metabolic/genetic/hearing tracking and surveillance database will provide useful information for statistical reporting and tracking.
The program will strive to maintain the 100% follow-up rate for entry into comprehensive medical care for children diagnosed with sickle cell disease or other metabolic disorder.
Public health nurses continue to follow-up this special needs population by provision of in-kind case management and care coordination services.
The program will continue to provide at least one annual in-service activity for health care providers and parents related to early and appropriate interventions to avoid serious medical complications or outcomes, and reduce morbidity and mortality due to life-threatening events.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 30 |
| Annual Indicator | | | 25.1 | 28.1 | 24.9 |
| Numerator | | | 280 | 300 | 320 |
| Denominator | | | 1117 | 1067 | 1284 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 30 | 35 | 35 | 40 | 40 |

**Notes - 2002**

This data is not available.

**Notes - 2003**

The Virgin Islands did not participate in the National SLAITS telephone survey. The State Title V needs assessment is anticipated to provide information needed to address this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.
VI did not participate in CSHCN survey.

## a. Last Year's Accomplishments

The VI did not participate in the national CSHCN survey. This information is not available

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
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## b. Current Activities

Family members participate on the V.I. Alliance for Primary Care, MCH Advisory Council, Needs Assessment Planning Group and the Medical Home Task Force. Bi-lingual family members are recruited for participation on these committees.
The program did not meet the characteristics of family members of children with special health care needs as paid staff or consultants specifically for the purpose of family advocacy. However, there are several administrative staff members who are parents of special needs children who access sub-specialty services

## c. Plan for the Coming Year

The Virgin Islands Title V Program plans to address this measure through continuation and strengthening of existing linkages and referral network.
Other strategies to be employed are: expand outreach and support to culturally diverse populations, providers and community organizations; identify barriers that prevent families from accessing health care on a regular basis; encourage family-professional partnerships in all program activities, i.e. include families in all workgroups, advisory committees and provide adequate compensation for their time; and encourage and promote participation to families, family advocacy organizations and providers.
In addition to the five year needs assessment, develop and administer periodic exit surveys to examine areas of family satisfaction such as care coordination, access to primary care, specialty and / or subspecialty care, participation in decision-making regarding therapies and plan of care and transition planning.
Provide cultural competency training for all program staff relative to working with children and families from culturally diverse backgrounds.
Other actions to achieve this goal are to enhance coordination with Child Find activities in Part C-IDEA Program, Department of Education-Special Education, Pre-School Education & Head Start Programs, and encourage participation through culturally sensitive and appropriate family training and education.

Training for staff, families and providers towards achievement of this goal will be provided in collaboration with a program partner, V.I. Family Information Network on Disabilities (VIFIND). This community based advocacy agency teaches parents about their rights under the Americans with Disabilities Act, IDEA and Section 504 of the Rehabilitation Act, and empowers them to actively participate in decisions affecting their child with special needs. Parents are assisted to locate information, resources, programs and services, and to communicate effectively with professionals and services providers.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 20 |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 20 | 25 | 25 | 30 | |

**Notes - 2003**

The MCH program is in the process of developing and implementing a medical home model in collaboration with the 330 funded Community Centers and private primary care pediatricians. Information obtained from the State Title V needs assessment is anticipated to address this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The definition of "Medical Home" as it's applied on the US mainland has a different meaning in the territory. The Title V program is considered the medical home as defined by the American Academy of Pediatrics, for a large percent of the CSHCN population. For many families the medical home is where a child with special health care needs and his or her family can count on having medical care coordinated usually by a public health nurse or service coordinator with the involvement of the pediatrician. These nurses and families work together and access all of the medical and non-medical services needed to help CSHCN achieve their potential. Factors that contribute to this are increasing numbers of underinsured and uninsured families; welfare

to work policies for single head of household families that offer low paying jobs with little or no medical insurance benefits or paid days off; and an overall poverty rate of 44.6% for children under 18 years in the territory. In addition, private pediatricians and other primary care providers routinely refer families to the program for access to specialty care not otherwise available.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
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## b. Current Activities

Families with private or group insurance may opt to remain with a private provider for primary care and access Title V services for specialty or sub-specialty care only.
Training in the Medical Home Model was accomplished this year. Participants included all MCH & CSHCN Program staff and invited partners, family members and representatives from community-based organizations and agencies that serve this population.
A Medical Home Task Force was convened as a result of this training. The task force is comprised of members of MCH medical and nursing staff, Infant & Toddlers Program and family members. The Task Force developed initial draft guidelines and protocols for successful implementation of medical home in the territory.

## c. Plan for the Coming Year

There is a demonstrated need for on-going professional education and training in the medical home model based on the American Academy of Pediatrics guidelines for all primary care providers in the territory. Training should include the core elements of the medical home concept as they can be adapted in the territory to meet the comprehensive needs of children and families. Existing partnerships such as those with the non-profit 330 funded health centers, private pediatricians and the Part C-IDEA Program will be utilized to plan, develop and implement an on-going training program.
A plan to promote the medical home approach through collaborations with community based organizations and professionals, i.e. child care providers, will assure their assistance in encouraging families to access the comprehensive and coordination available in a medical home.
Technical assistance will be requested from MCHB to provide funding for consultants to provide the follow-up training and program evaluation required for implementation of medical home.
Complete draft recommendations for implementation of medical home.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | | | | | |

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

This measure is not directly applicable to the territory. There is a Medicaid cap that places severe limitations on the ability to provide insurance for eligible families. SCHIP funds are utilized to pay unpaid medical expenses for children with Medicaid.
There are no HMO's, MCO'S or PPO's providing Medicaid managed care coverage.
Some private sector employers provide medical benefits for their employees with no family coverage options.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

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b. Current Activities

A sliding fee scale is available for clinic services. Income eligibility is based on 200% of the federal poverty income guidelines.
The Government of the Virgin Islands requires all of its employees to be covered by group medical insurance. The current carrier, CIGNA, is considered a PPO with most local providers a part of the network. Families without health insurance are less likely to have a regular source of care and access the health care system only when necessary in order to avoid out-of-pocket costs. The Title V program provides access to services, i.e. diagnostic, laboratory, specialty and sub-specialty care for families with no insurance coverage who are not eligible or do not meet certification standards for the Medical Assistance Program.

c. Plan for the Coming Year

The program will continue to provide sub-specialty clinics to children with special health care needs utilizing contracted pediatric sub-specialists. Sub-specialists from Puerto Rico conduct monthly clinics in pediatric neurology, orthopedics, hematology, pulmonology and cardiology. All children in the territory have access to these services regardless of source of payment or ability to pay for services. The availability of these services has reduced the high cost of off-island travel, enabled the clinics to be community-based, increased communication, reduced lost time from work for parents/caregivers, and enhanced the quality and continuity of care. Off-island referrals are primarily for diagnostic services such as cardiac catheterization, cardiac sonography, brainstem audio-evoked response testing, and less frequently, oncology, endocrinology, gastro-enterology and neuro-psychology services that are not available on-island for the pediatric population.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 30 | 30 | 30 | 30 | 30 |
| Annual Indicator | NaN | NaN | | | |
| Numerator | 0 | 0 | | | |
| Denominator | 0 | 0 | | | |

| Is the Data Provisional or Final? | | | | | |
|---|---|---|---|---|---|
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 30 | 30 | 30 | 30 | |

**Notes - 2002**

In the Year 2000 needs assessment, 2.7% of CSHCN clients stated they obtained family support services and were satisfied with them.

**Notes - 2003**

Information obtained from the five year needs assessment is anticipated to address this measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

## a. Last Year's Accomplishments

The VI did not participate in the national CSHCN survey.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
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## b. Current Activities

The program providesinformation and referral services to appropriate agencies based on families identified needs.

## c. Plan for the Coming Year

The program has existing collaborative partnerships with community based organizations that provide services to children and families. These include but are not limited to advocacy groups, legal services, resource and training centers, child care providers, family support and faith based organizations.
The V.I. Alliance for Primary Care and the MCH Advisory Council, which includes members from these organizations are the focal point for developing and maintaining these community collaboratives to promote partnerships between families and service providers.

Technical assistance is being requested to provide training on community needs assessments and community based services systems development.
Continue to assist families in accessing services based on identified needs.
Develop and implement a referral / feedback system for tracking purposes.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | | | |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | | | | | |

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

VI was not included in the national CSHCN survey. This percentage is unknown.
The program has developed a draft plan for youth and adolescents with special health care needs transitioning to adulthood. The plan is based on the Healthy and Ready to Work model which facilitates the integration of service systems to address the health issues of this population. The MCH Program is collaborating with the State Office of Special Education to develop goals and strategies for effective transition using a team approach.
The plan supports skill-building opportunities for youth and their families. It supports their involvement as decision makers in their health care, education and employment.
Other agencies identified as stakeholders include: Departments of Education, Vocational Education; Department of Human Services, Vocational Rehabilitation; Department of Labor, Job Training and Placement; Community Health and 330 Centers; community based organizations, i.e. V.I. Resource Center for the Disabled, University of the Virgin Islands Center for Excellence on Developmental Disabilities, Virgin Islands Assistive Technology Foundation, Inc., Family Voices, V.I. Center for Independent Living, and V.I. Family Information Network on Disabilities.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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b. Current Activities

Staff training provided on activities of the Virgin Islands Assistive Technology Foundation, Inc. which provides alternative funding opportunities to individuals with disabilities in need of loans for assistive technology devices and services.
Transition planning with families provided by public health nurses.

c. Plan for the Coming Year

Facilitate interagency collaboration to share resources and skills.
Use information received from the needs assessment to promote transition planning from pediatric to adult health care.
Reconvene a Transition Planning team to develop and implement a transition planning health care plans for families of all children and adolescents with special health care needs.
Continue collaboration with other agencies and community-based partners to address health care transition issues.
Technical assistance will be provided to MCH staff, partners, families and community agencies to facilitate the development of strategies for collaboration and communication that will assist families and adolescents in transition planning.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 90 | 91 | 92 | 90 |
| Annual Indicator | 92.0 | 85.0 | 96.0 | 82.0 | |
| Numerator | 3717 | 3132 | 3315 | 7330 | |
| Denominator | 4041 | 3685 | 3454 | 8940 | |
| Is the Data Provisional or Final? | | | | Provisional | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |

**Notes - 2002**

Numerator represents estimates of data obtained from Day Care and Head Start Immunization Assessment Report by Immunization Program and clinic immunization reports for the specified age group.
Denominator for 2001 and 2002 represents population data from U.S. Census 2000.

**Notes - 2003**

The numerator represents Year 2000 Census data for this population in the territory.
The denominator is the number of children with immunizations completed by 35 months.
All data obtained from the Immunization Program Registry.

**Notes - 2004**

Data for this measure is unavailable from the Immunization Registry.

## a. Last Year's Accomplishments

Technical challenges and deficiencies with the Immunization Registry are not resolved. Data required for this performance measure is not available from the Immunization Program.
Random medical record audits (n=200) for this age group showed that 31% met the criteria for this measure. This audit was completed on St. Thomas only.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
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## b. Current Activities

The Women, Infants and Children Nutrition Program (WIC) ensured that children participating in the program completed their immunization schedule through age 2. Participants who are not up to date with their immunization are referred to the Immunization Clinic as per Memorandum of Understanding that VI WIC has with the immunization program according to policy and procedure 2.09.
A random sampling of 13 schools showed that 85% of kindergarten ages children (n=580) were up to date with recommended immunizations and 90% has received Varicella.
MCH staff participated in training activities sponsored by the Immunization program.

### c. Plan for the Coming Year

The Vaccine For Children Program's mandate related to uninsured or Medicaid eligible/certified children can qualify to receive vaccine through from the program is being implemented.
Discussion with the DOH-MIS staff to track immunization information on the Health-Pro System will continue. This is especially crucial since the Immunization Registry is not likely to produce valid and / or reliable data for FY 2005 reports. FY 2006 projections for this age group (19-35 months) estimates 6,537 children.
No major changes are planned for immunization services. Immunization will continue to be a vital part of every primary and preventive care visit at MCH clinics, the community heath centers and other clinics.
The program will continue to strive for at least 95% of all children receiving services with complete recommended immunizations by age 3 through continuous assessment of immunization status and parental education.
Annual quality assurance reviews via random chart audits to determine compliance with recommended immunization guidelines will be conducted quarterly. In addition to measuring compliance with vaccine schedules, the reviews will identify areas such as missed opportunities, barriers faced by parents when attempting to vaccinate their children and provide a mechanism to document recommendations to improve rates.
In order for MCH & CSHCN clinical staff to keep up with ever changing immunization policies, promote attendance at training sessions and annual immunization conference. Continue efforts to raise immunizations rates through public and provider awareness.

## Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 50 | 50 | 49 | 30 | 20 |
| Annual Indicator | 31.1 | 31.8 | 25.2 | 24.4 | 23.4 |
| Numerator | 93 | 97 | 77 | 74 | 71 |
| Denominator | 2991 | 3051 | 3051 | 3039 | 3039 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| | | | | | |

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|---|---|---|---|---|---|
| Annual Performance Objective | 20 | 15 | 15 | 15 | 15 |

**Notes - 2002**

Denominators for years 2001 and 2002 reflect U. S. Census 2000 data.

## a. Last Year's Accomplishments

The Family Planning Program provides voluntary services primarily to low-income women. The program enables individuals, mostly women of childbearing age, and families to achieve their goals for family size. The program worked to improve adolescents' understanding of human sexuality and contraception. The program provided medical evaluations, human sexuality and contraceptive counseling, infertility management, genetic counseling, referrals and health education. Improved clinic access and adolescent outreach activities that provide risk reduction education and counseling are among the services offered to this population.
The Family Planning Program continues to experience success in all areas of services offered. A total of 1,360 adolescents were reached through direct clinic services (a slight 4.7% decrease over FY 2003's 1,425 visits). A significant 49.3% decrease in outreach visits (718) for FY 2004 was experienced. Outreach sessions were made possible through the efforts of clinical nurse educators and adolescent peer educational group (which generated 185 contacts). A total of 8,187 family planning visits were generated - a 13.5% (973 of 7,214 over FY '03 )visits . The rate (59.0%) for appointments continues to improve over the FY 03 rate (58.3). This implies better adherence to appointments. St. John has the best compliance rate (86.5). This year, teens comprised 16.6 of all visits as opposed to FY 03 (19.8%). The slight decrease implies a need to expand outreach to teens. It may also include teens who have Agraduated@ to adult status within the program. Clinical nurse educators conducted 19 outreach sessions with 533 teens in attendance despite their busy schedules. With the recruitment of a teen coordinator on St. Croix, improvement in outreach capacity is anticipated to be realized. Screening for GC/Chlamydia in collaboration with the STD/HIV/TB Program shows a decrease in positivity rate for chlamydia.

During the period 10/01/03-9/30/04, the Adolescent Health Progra has successfully undertaken activities consistent with the program's performance measures:
.. Reduce the rate of pregnancy to teenagers aged 15-17 years.
.. Reduce the proportion of adolescents who have engaged in sexual intercourse. Reduce the incidence of youth 15-19 years who have contracted selected sexually transmitted diseases.
.. Reduce the rate of births to female teenagers aged 15-17 years.
.. Reduce the percentage of live births, by 1% annually, to mothers less than 18 years and fathers 20 years or older--DH determined.
.. Increase, by 85%, the proportion of adolescents aged 13-18 years who have discussed sexual abstinence in the avoidance of out-of-wedlock pregnancy and STD's in a coeducational setting.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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b. Current Activities

To date, the most effective avenue for marketing the sexual abstinence message continues to be voice interaction via radio talk shows, live audiences and radio public service announcements; and as such, proven effective.
Data to report on this measure is not available from the Office of Vital Records and Statistics.

c. Plan for the Coming Year

The Family Planning Program will continue to strive to increase awareness, especially to adolescents on choices and consequences as it relates to sexual involvement. Outreach staff will continue to provide sessions specifically for teens.
The Family Planning Program will continue to provide access to comprehensive services, STD counseling and testing, with special counseling for teens.
Outreach and community education efforts will continue to provide information through print, radio and TV media.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 50 | 55 | 56 | 30 | 30 |
| Annual Indicator | 0.0 | 0.0 | 30.4 | 0.0 | 0.0 |
| Numerator | 0 | 0 | 2475 | 0 | 0 |
| Denominator | 6034 | 8148 | 8148 | 8148 | 9144 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 30 | 35 | 35 | 35 | 35 |

**Notes - 2002**

The Division of Dental Health data reflects the total number of children that received any dental services. Data specific to protective sealants in this age group is not obtained.
Denominator reflects U.S. Census 2000 data for this age group.

**Notes - 2003**

Denominator reflects 2000 Census data.
The DOH Division of Dental Health reported no sealants offered during this fiscal year due to insufficient funding.

**Notes - 2004**

Denominator obtained from 2003 VI Community Survey by University of the Virgin Islands Eastern Caribbean Survey.
Total # of 5-9 year olds.

## a. Last Year's Accomplishments

Dental services available at the dental clinics administered by the Department of Health. Services include: examinations, fluoride applications, fillings and extractions. Sealants are not offered due to lack of funding. The Medical Assistance Program does not cover this service for enrolled children.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
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| | DHC | ES | PBS | IB |
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## b. Current Activities

The Title V Program provided financial assistance for CSHCN requiring surgical or periodontal treatment that were not covered by the Medical Assistance Program.
It is not anticipated that the Medicaid Program will have the resources to cover this service for VI children. Dental clinics will continue to provide other oral health services, including assessment, oral examination, fluoride applications, restorative fillings and extractions.
An Early Head Start / Head Start Oral Health Task Force was convened to develop an interagency plan for this population and their families that improves their access to oral health education, prevention and treatment. Several agencies and a pediatric dentist were represented. This initiative is not limited to this specific population and includes the entire early childhood population in the territory. This is a vital issue given the large percent of young children with dental caries requiring surgical intervention by age 4.

## c. Plan for the Coming Year

The water supply in the Virgin Islands is not fluoridated. The use of sealants and fluoride has been proven to reduce or eliminate decay in the permanent teeth of children. Though this measure relates to a population based preventive service, providing sealants will impact on direct care service dollars. Funding will be allocated from the Title V Block Grant to assist with purchase of sealants and other supplies needed for these services.

Funding is being requested from ACF Head Start Oral Health Initiative for Young Children, Birth to Five, with Lutheran Social Services as the applicant in collaboration with other relevant and appropriate agencies including the Title V Program.
Community partnerships established with the pediatric dentist to assist the program in providing the spectrum of oral health services especially to the CSHCN population will be continued. These partnerships are anticipated to address community needs related to oral health and provide education to students, families, child care providers and other professionals related to maintaining healthy teeth, prevention of tooth decay and proper nutrition.
In addition, they will provide improved increased access to dental services and expand sources of protective sealants.
Oral Health education and promotion activities targeting the general public will be developed utilizing PSA's, bilingual messages, posters, etc.
Training for physicians and other health care providers in oral health screening as part of routine health care will be undertaken.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 3.6 | 3.4 | 3.4 | 3.3 | 3 |
| Annual Indicator | 4.3 | 10.6 | 0.0 | 3.6 | 0.0 |
| Numerator | 1 | 3 | 0 | 1 | 0 |
| Denominator | 23241 | 28405 | 28405 | 27564 | 27564 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 3 | 3 | 3 | 3 | 3 |

**Notes - 2002**

Data for Year 2000 not available. The Vital Statistics Registry does not have a cause of death coder on staff.
Year 2001 data reflects the total number of deaths in this age group.
There were no reported deaths due to motor vehicle crashes in this age group for year 2002.
Denominator for years 2001 and 2002 obtained from U.S. Census 2000 data.

**Notes - 2003**

There are twelve recorded deaths in the age group 14 and younger. Motor vehicle crashes is not listed as cause of death.

a. Last Year's Accomplishments

This data is not available from the Office of Vital Records and Statistics. There is not a Child

Death Fatality Review Committee in the VI.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
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| | DHC | ES | PBS | IB |
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b. Current Activities

There are no official reported deaths in this age group due to motor vehicle crashes.
The Emergency Medical Services training staff provided injury prevention, infant and child safety, traffic safety including bike, skating, and motor vehicle passenger safety education to students, school staff, community organizations and other providers throughout the year. In addition, first responder and basic cardio-pulmonary resuscitation training were offered.
A pubic awareness and information campaign utilizing public service announcements and print media related to injury prevention is on-going.
The Division of Emergency Medical Services is located organizationally within the Department of Health. In addition, the Office of Highway Safety has on on-going media campaign regarding substance use (alcohol and other drugs) and driving.
The Vital Statistics Registry is unable to provide information due to lack of a statistician and / or a cause of death coder.

c. Plan for the Coming Year

The program will continue to partner with VI-EMS and Office of Highway Safety in collaboration with the EMS-C Partnership Project to promote injury prevention and traffic safety activities in the community.
School-based health center providers will be included in this partnership.
Increase public awareness activities to include alcohol and other substance abuse safety issues as related to motor vehicle use.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| **Annual Objective and** | **2000** | **2001** | **2002** | **2003** | **2004** |

| Performance Data | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 81 | 82 | 55 | 85 |
| Annual Indicator | 59.4 | 54.1 | 53.5 | 86.0 | 51.9 |
| Numerator | 999 | 958 | 908 | 1384 | 868 |
| Denominator | 1682 | 1772 | 1698 | 1610 | 1672 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 85 | 85 | 85 | 85 | 85 |

**Notes - 2002**

Data obtained from WIC Program surveys of breast feeding and non-breast feeding post partum clients at hospital discharge.

**Notes - 2004**

Numerator reflects data from period October 2003 - June 2004 provided by WIC Program.

## a. Last Year's Accomplishments

The Virgin Islands WIC Program continues all efforts to actively promote, support and protect breastfeeding within the territory. VI WIC continues to remain the ‘beacon of light' for breastfeeding promotion within the islands, as the only organization, which consistently promotes and supports breastfeeding within the territory.
The WIC Program is dedicated to the delivery of quality nutrition education and counseling, intervention, referral and follow-up on identified risks to improve low-income nutritionally at-risk, pregnant and breastfeeding women, infants and children.
Nutrition education is an important component of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) to help in improving the health and nutritional status of its target population.
Provided breastfeeding information to all prenatal clients at certification as well as individualized assistance to breastfeeding moms with problems.
VI WIC breastfeeding women data indicates that 85% of postpartum women breastfeed. Each island also shows an 85% breastfeeding rate.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
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b. Current Activities

WIC continues to provide part time breastfeeding counselors in both the Juan F. Luis and Roy L. Schneider Hospitals to assist with breastfeeding promotion and support within these institutions. These counselors many times provide the difference between WIC participants receiving breastfeeding assistance, to no assistance being given at all.
VI WIC updated and reprinted the hospital discharge booklet given to moms discharged from the hospitals. This included the renaming of the booklet from Breastfed Is Best-fed to Breastfeeding Is Baby's Best Start. A WIC breastfeeding mom was used in the booklet.
The cooler to distribute to 100% breastfeeding moms leaving the hospital was also updated and repurchased.
Roy L. Schneider Hospital Breastfeeding Counselor attended the La Leche League's 32nd Physician's Seminar on Breastfeeding held in Newport, Rhode Island, July 26 -- 28, 2004.
Breastfeeding information was provided to all prenatals at certification. Breastfeeding moms were also provided with support and individual assistance if they had any breastfeeding problems. 138 moms (19% of average 738 BF moms) received direct assistance for breastfeeding problems in WIC clinics.
A breastfeeding promotion campaign via media (radio, television and newspapers) was executed during World Breastfeeding Week and the rest of August. All advertisements were done locally. Television advertisements used WIC moms.
During World Breastfeeding Week and for the rest of August, WIC child participants received, Read and Color pamphlets that featured a breastfeeding picture to color, a breastfeeding story for moms to read to children and tips to encourage reading on the back. Participants were encouraged by WIC staff to read to their children.
Nutrition Education and WIC program materials translated in Spanish are available to serve our Spanish speaking population.

c. Plan for the Coming Year

To continue the Baby Friendly Initiative in the Juan F. Luis and Roy L. Schneider Hospitals.
To ensure that the WIC Program continues to promote, support and protect breastfeeding among WIC participants.
Continue efforts to ensure mothers that breast milk alone is sustainable to babies for up to six months. WIC will also continue to provide support for breastfeeding mothers who work.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance | 96 | 96 | 97 | 90 | 95 |

| | | | | | |
|---|---|---|---|---|---|
| Objective | | | | | |
| Annual Indicator | 56.3 | 35.9 | 47.0 | 94.5 | 86.8 |
| Numerator | 947 | 637 | 798 | 1521 | 1449 |
| Denominator | 1682 | 1772 | 1698 | 1610 | 1670 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 95 | 95 | 95 | 95 | 95 |

**Notes - 2002**

Year 2001 data reflects screening at the Juan F. Luis Hospital on St. Croix only.
For year 2002, 1 screening technician was available at the Roy L. Schneider Hospital on St. Thomas.
See further discussion under this performance measure.

## a. Last Year's Accomplishments

The population-based service, Universal Newborn Hearing Screening Program, continued to function in partnership with the Infants and Toddlers Program. The MCH Audiologist on St. Croix performed auditory brainstem response tests (ABR). Patients from St. Thomas and St. John travel to St. Croix for follow-up testing and diagnostic evaluations, therefore eliminating the costs incurred for travel to Puerto Rico.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
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## b. Current Activities

The addition of hearing screening technicians ensures increased availability of screening. Initial screening rates have increased significantly from forty (40) to ninety-six (96) percent (2004) territory wide since the inception of screening in 1999.
Guidelines and protocols for the EHDI Project were completed by the Advisory Committee.
Program evaluation by National Center for Hearing Assessment and Management (NCHAM was done. Both provider and parent satisfaction surveys were performed.
The integrated newborn screening database was modified and updated to provide reports. The

database currently provides data on birth admission, follow-up outpatient screening and audiological diagnostic reports.
A Memorandum of Agreement between the MCH & CSHCN Program and the Infants & Toddlers Program for provision of early intervention services for children identified and diagnosed with a permanent hearing loss is completed and submitted for approval. The purpose of this agreement is to clearly state the responsibilities of each agency in assuring that newborns are identified early for suspected or confirmed hearing loss and are receiving appropriate family centered intervention services.

### c. Plan for the Coming Year

This will be the final year of funding from the CDC-EHDI Projects.
The Newborn Hearing Screening Program will continue using portable otoacoustic emissions equipment to test newborns at the two hospitals on St. Thomas and St. Croix. Newborns who need follow-up screening will be referred to the Infants and Toddlers (Early Intervention) Program. Brainstem audio-evoked response tests are conducted by the MCH and CSHCN Program audiologist on St. Croix.
Screening will be made available on St. John one day a week upon completion of the Morris F. deCastro Clinic, a Department of Health facility. This activity is intended to provide screening to infants who missed the hospital initial screening or need follow-up outpatient screening, or those who are home birthed. Based on demand, a hearing screening technician will be assigned on additional days.

## Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 20 | 18 | 16 | 15 | 15 |
| Annual Indicator | 25.2 | 25.5 | 13.4 | 9.0 | 0.0 |
| Numerator | 10079 | 10079 | 5277 | 3565 | 0 |
| Denominator | 40031 | 39502 | 39502 | 39502 | 36058 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 15 | 15 | 15 | 15 | 15 |

**Notes - 2002**

Best data available from Medicaid Program:
Estimates of children 0-17 years below poverty = 14,210
Potentially eligible medicaid children 1-21 years = 8,933
Numerator = children without health insurance - potentially medicaid eligible children
Denominator = total number of children 0-21 years obtained from U.S. Census 2000 data

**Notes - 2003**

The numerator represents only children registered and receiving services at the MCH clinics. Data from the Medical Assistance Program is unavailable.

**Notes - 2004**

Data for this measure not available from Medical Assistance Office.

### a. Last Year's Accomplishments

Children with Special Health Care Needs are disproportionately low-income, and because of this, they are at greater risk for being uninsured. Moreover, their needs for health care are greater. MCH and CSHCN Programs refer families to MAP for eligibility determination.
There is no formal outreach program for the MAP or CHIP Programs, since there are such limited resources to offer the families.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
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### b. Current Activities

Families determined to be eligible for the Medical Assistance Program based on the federal income guidelines for poverty are referred to the MAP Program.

### c. Plan for the Coming Year

All children registered in the Title V program receive services regardless of insurance availability or ability to pay.
Uninsured children will continue to be provided financial assistance for access to diagnostic, specialty and sub-specialty care.
Families without health insurance will continue to be referred to the Medical Assisance Program to determine eligibility.

## Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| | | | | | |

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 96 | 97 | 98 | 98 | 50 |
| Annual Indicator | 98.3 | 87.3 | 62.9 | 54.9 | 0.0 |
| Numerator | 9894 | 8787 | 8933 | 7807 | 0 |
| Denominator | 10061 | 10071 | 14210 | 14210 | 14210 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 50 | 55 | 55 | 55 | 55 |

a. Last Year's Accomplishments

The MAP data system does not have the capability to generate specific claims data related to children and the services received.
The Medical Assistance Program (MAP) functions under a cap for fiscal year 2003 and a ratio of Federal and Local matching of 50/50.
Mandatory Medicaid services include inpatient hospital, outpatient hospital, health clinic services, laboratory & x-ray services, Early & Periodic Screening, Diagnosis & Treatment, Family Planning, Nursing Home Services, Physician services that must be pre-authorized, and Dental services.
Optional services (but covered) are optometrist services, eyeglasses, prescribed drugs, air transportation, and respiratory therapy.
Optional services (not covered) are services in institutions for mental illness, hospital transfer/air ambulance transportation, dentures prosthetic devices, physical and occupational therapy, and/or durable equipment.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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## b. Current Activities

CSHCN are disproportionately low-income, and because of this, they are at greater risk for being uninsured. Moreover, their needs for comprehensive, long-term health care are greater. MCH and CSHCN Programs will refer families to the MAP for eligibility determination. However, The Title V program continues to be the safety net for MAP eligible children who are unable to access services.
Translation services will continue to be available at clinics through bilingual staff. Translation is available for Spanish-speaking clients and for French dialects from the eastern Caribbean islands.
Transportation services are not routinely offered, but can be arranged upon request. Off-island air transportation may be provided based on need and availability of funds.
Home visitation is provided on a priority basis for high-risk clients by MCH & CSHCN Program public health nurses.

## c. Plan for the Coming Year

The Title V program continues to be the safety net for MAP eligible children who are unable to access services otherwise.
All children registered in the program will continue to receive access to services regardless of third party insurance status or ability to pay.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 1.5 | 1 | 1 | 2 | 2 |
| Annual Indicator | 2.1 | 1.8 | 2.0 | 2.2 | 1.9 |
| Numerator | 36 | 32 | 34 | 36 | 32 |
| Denominator | 1682 | 1772 | 1698 | 1610 | 1672 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 2 | 2 | 2 | 2 | 2 |

## a. Last Year's Accomplishments

Risk factors associated with a high incidence of LBW babies are lack of prenatal care, alcohol and substance abuse, poor nutrition and infectious disease. The Virgin Islands Healthy Start Initiative, V. I. Perinatal Partnership (VIPP) focused on strengthening and enhancing the perinatal care systems in order to address the medical, behavioral and psychological needs of women and infants and to promote healthy births.

The VIPP Consortium and staff made great strides fiscal year 2003. There are more consumers represented and the training plan under the VIPP Consortium Leadership Institute was implemented.
Case management remains the core system, which centers upon individual assessment and creation of individual perinatal service plans. The plan is developed with the case manager and client and serves as a guide for clients as they navigate through the integrated system of perinatal care. Neighborhood outreach efforts to identify more women at risk for poor pregnancy outcomes. Services provided included health education and counseling, nutrition counseling, smoking and substance use cessation, in efforts to assure early and adequate prenatal care and improved birth outcomes.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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b. Current Activities

The infant mortality rate on St. Croix where the Healthy Start Program is based, remained at 1.3% of live births. Outreach and case management activities continue to identify women at risk and promote healthy lifestyles during pregnancy with the goal of improving birth outcomes and a reduction in low/very low birth weight infants.

c. Plan for the Coming Year

Perform evaluation of VIPP to determine program effectiveness. The emphasis is on comparing stated objectives and performance standards with actual achievements of the program.
Assess accomplishments and performance data to determine whether the program's performance is as effective as established standards.
Continue to encourage and facilitate consumer awareness, knowledge and participation to foster healthy birth outcomes.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| **Annual** | | | | | |

| Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 10 | 8 | 8 | 8 | 5 |
| Annual Indicator | NaN | 0.0 | 0.0 | 0.0 | 0.0 |
| Numerator | 0 | 0 | 0 | 0 | 0 |
| Denominator | 0 | 9719 | 8688 | 8688 | 8494 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 5 | 5 | 5 | 5 | 3 |

**Notes - 2002**

Data not available. The Vital Statistics Registry lacks a cause of death coder.

**Notes - 2003**

There is 1 recorded death in the age group 15-19. The cause of death is not available from the Vital Statistics Registry.

## a. Last Year's Accomplishments

Due to a vacancy in a coder position in the Vital Records Unit, no cause of death data is available.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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## b. Current Activities

"Promoting Children's Mental Health Systems" was the focus of the V. I. Alliance for Primary Care Annual Meeting this year. Workgroups were formed to develop a comprehensive children's mental health plan for the territory including assessment tools for use in all clinic services.

Children and adolescents with SED needing multi-agency services will receive them in a

coordinated fashion.
Adequate and appropriate crisis intervention and crisis stabilization services targeted for children and adolescents are a proposed component of the system, to avoid placement in adult facilities

### c. Plan for the Coming Year

Continue work on comprehensive plan. Provide preventive educational material to school based health clinics.
Mental health services is a component of the school-based health centers to be implemented in school year 2003-2004 with the 330 health centers.
The Department will seek to fill a vacancy in a coder position in the Vital Records Unit in order to make cause of death data is available.
The MCH & CSHCN Program will continue collaboration with the Department of Education, Special Education Program, Children's Mental Health Task Force to assure information and referral sources for families of children requiring mental health assessment, management and treatment.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 25 | 30 | 35 | 0 | 0 |
| Annual Indicator | NaN | NaN | | | NaN |
| Numerator | 0 | 0 | | | 0 |
| Denominator | 0 | 0 | | | 0 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 0 | 0 | 0 | 0 | 0 |

**Notes - 2002**

This measure is not applicable to the Virgin Islands, facilities for high risk deliveries and neonates are not available. Maternal high risk patients are transported to Puerto Rico for delivery.
There are Level II NICU's both staffed by a Neonatologist. High risk neonates delivered locally are transferred to Level III NICU's in Puerto Rico or Miami.

**Notes - 2003**

There are no Level III facilities in the Virgin Islands. All high-risk prenatal patients are

transferred off-island for care.

### a. Last Year's Accomplishments

There are no Level III facilities in the Virgin Islands. This NPM is not applicable.
A Level II nursery exists on St. Thomas, which is headed by a neonatologist. In 1999, a neonatologist was added to the staff of the Juan F. Luis Hospital on St. Croix. As a result, infants are no longer transferred from St. Croix to St. Thomas for Neonatal Intensive Care. Newborns requiring neurosurgery or cardiac surgery may be transferred to Puerto Rico or Florida.
Coordination and communication among health care and related systems were maximized to increase service utilization, and minimize gaps and duplication. The infrastructure for provision of services was strengthened in order to make a meaningful impact on the health status of women.
The Territorial Perinatologist led the development of protocols for the treatment of high-risk prenatal patients.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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### b. Current Activities

There are no plans to open a Level III nursery in the Virgin Islands. Present arrangements will be continued.
Prenatal clinics will perform appropriate risk assessment and encourage women to seek care for signs of early labor.

### c. Plan for the Coming Year

There are no plans to open a Level III nursery in the Virgin Islands. Present arrangements will be continued.

## Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 90 | 90 | 65 | 65 |
| Annual Indicator | 64.1 | 66.3 | 64.5 | 63.2 | 63.3 |
| Numerator | 1078 | 1175 | 1095 | 1018 | 1059 |
| Denominator | 1682 | 1772 | 1698 | 1610 | 1672 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 65 | 65 | 65 | 60 | 60 |

## a. Last Year's Accomplishments

The MCH Unit provides primary and preventative care to pregnant women, mothers and infants. Women are able to receive comprehensive reproductive health care.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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## b. Current Activities

See discussion under PM#15.

## c. Plan for the Coming Year

Continue partnerships with programs that encourage early enrollment in early prenatal care, i.e. Family Planning, VIPP, Ryan White Title IV through outreach, education and awareness activities.
Prenatal clinics will perform appropriate risk assessment and encourage women to seek care for signs of early labor.

## D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of pregnant women who receive no prenatal care*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 3.5 | 3.3 | 3.3 | 3 | 2.5 |
| Annual Indicator | 4.5 | 2.8 | 4.5 | 4.5 | 0.0 |
| Numerator | 76 | 49 | 77 | 72 | 0 |
| Denominator | 1682 | 1772 | 1698 | 1610 | 1672 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 2.5 | 2.5 | 2.5 | 2 | 2 |

**Notes - 2003**

Incomplete data received on this measure at time of report. Complete data not expected by due date of this report.

### a. Last Year's Accomplishments

The number of women who did not receive prenatal care in 2002 was 77 and 68 in 2003. In 2001, 49 women did not receive prenatal care.
Prenatal services were provided in MCH Clinics, community health centers, family health centers and private clinics. The MCH Unit provides primary and preventative care to pregnant women, mothers and infants. Women are able to receive comprehensive reproductive health care. (See discussion under Performance Measure 18.)
The Family Planning Program offers prenatal patients comprehensive, quality care and counseling and referrals are made to the MCH and Community Health Prenatal Clinics for full-term obstetrical / medical care.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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b. Current Activities

See discussion under NPM 15 and 18.

c. Plan for the Coming Year

See discussion under NPM 15 and 18.

State Performance Measure 2: *The rate ( per 1,000) of reported cases of HIV-positive mothers who received antiviral treatment to reduce perinatal transmission of HIV.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 150 | 150 | 10 | 10 | 5 |
| Annual Indicator | 0.6 | 0.0 | 2.9 | 0.0 | 30.5 |
| Numerator | 1 | 0 | 5 | 0 | 51 |
| Denominator | 1682 | 1772 | 1698 | 1610 | 1672 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 30 | 30 | 30 | 30 | 30 |

**Notes - 2002**

Data available from STD/HIV/AIDS Program reflects 5 HIV+ prenatal patients were referred for treatment.

a. Last Year's Accomplishments

The Virgin Islands has a high rate of AIDS cases with an incidence rate of 24.8% per 100,000 population, and HIV cases at 21.2% per 100,000 population. Black and Hispanic females ages 20-49 are at greatest risk of heterosexual infection. This measure was selected to address efforts for reduction of perinatal transmission of HIV. It also relates to the priority need for improving birth outcomes. Early identification and management with ART has been shown to significantly reduce transmission to newborns.
Of significance is that of 12 women reported to be HIV positive in 2003, none were reported by the Office of HIV/AIDS Surveillance Program to deliver HIV positive infants. It is unclear if any of these women were pregnant at any time during this period.

The Perinatal High Risk Clinic provides treatment and management to reduce the incidence of perinatal transmission.
Rapid testing is available in both hospitals Labor & Delivery units if documentation of HIV testing does not exist.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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b. Current Activities

HIV testing is offered to all prenatal patients with pre and post counseling.
Ryan White IV Project provides access to coordinated, comprehensive clinical services and anti-retroviral treatment for HIV-positive pregnant women.
Access to medical care by a Perinatologist is provided.
Family counseling and partner testing and treatment are available.

c. Plan for the Coming Year

The MCH Unit will continue to provide primary and preventative care to pregnant women, mothers and infants. Women enrolled will receive comprehensive reproductive health care, including access to STD and HIV counseling and were encouraged to have periodic testing.
Review existing policy regarding follow-up of pregnant women testing positive for HIV to ensure that all women are offered counseling and treatment options.
Continue partnerships with other programs, agencies and organizations that provide support services to families of women, children and adolescents identified as HIV positive.
Increase access to confidential HIV testing and counseling for women and adolescent youth.
The Family Planning Program will continue to provide OraSure (HIV) testing and referral services for HIV-positive women and adolescents.
Ryan White IV Project will continue to provide outreach, testing and counseling to the target population, women and adolescents of child-bearing age.
Outreach and education activities to the target population, women, children and adolescents, will continue in collaboration with Family Planning, VIPP, 330 Health Centers, MCH and Community Health Prenatal Services.

State Performance Measure 3: *Percent of prenatal patients certified with the medical*

*assistance program (MAP)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 60 | 60 | 61 | 30 | 25 |
| Annual Indicator | 0.0 | 25.5 | 23.9 | 13.0 | 13.0 |
| Numerator | 0 | 452 | 406 | 209 | 217 |
| Denominator | 1682 | 1772 | 1698 | 1610 | 1672 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 25 | 20 | 20 | 20 | 20 |

**Notes - 2002**

This measure relates to percent of live births to prenatal patients receiving Medical Assistance. This estimate is based on data received from the DOH Community Health & MCH Prenatal Clinics.
This information is not available from the Medicaid data system.

**Notes - 2003**

This data is not reported by the Medical Assistance Program.
The data reported only reflects prenatal clients receiving services at the MCH Prenatal Clinic on St. Croix. St. Thomas data is unavailable.

**Notes - 2004**

Numerator reflects clients served at MCH and Community Health Prenatal services only.
Data from Medical Assistance Office not available.

a. Last Year's Accomplishments

Eighty (80) percent of clients at the MCH prenatal clinic had Medical Assistance (MAP) as their only insurance coverage.
The MCH Program facilitated enrollment of prenatal patients for Medicaid at all prenatal clinics. Eligible patients were referred to MAP for evaluation.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
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b. Current Activities

Assistance in applying for Medicaid is provided to users of Title V services through social workers at the MCH & CSHCN facilities. Social workers inform clients of the necessary documents needed at the time of registration, i.e. birth certificates, passports, naturalization papers, etc.
In addition, information is provided about location of MAP offices, hours of operation, and how patients should apply for Medicaid.
MAP eligible patients are identified at a variety of sites including outpatient ambulatory facilities, hospital facilities, and other government agencies such as the Department of Human Services. Patients who are low-income, uninsured, pregnant, or have special health care needs are referred to Social Services or the MAP offices directly for eligibility determination.

c. Plan for the Coming Year

The MCH Program will refer all potentially eligible prenatal patients to MAP for eligibility determination.

State Performance Measure 4: *Rate of asthma hospitalizations*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | 160 | 150 | 150 | 20 | 10 |
| Annual Indicator | | | 15.8 | 0.0 | 17.6 |
| Numerator | | | 45 | 0 | 49 |
| Denominator | | | 28405 | 28405 | 27781 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 10 | 10 | 10 | 10 | 10 |

**Notes - 2004**

Numerator reflects hospitalizations in ages 0-5 years only.

a. Last Year's Accomplishments

The MCH Program provided direct care and pediatric pulmonology consultation services for children with asthma. A monthly pulmonology Clinic provided comprehensive management, preventive and primary care, and educated parents on dealing with asthma and self-management.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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b. Current Activities

Hospitalizations with asthma as the primary cause for admission were reported to be zero (0) for FY'03 in the 0-5 age group on St. Thomas. Data for St. Croix is not available.

c. Plan for the Coming Year

Collaborative efforts with other health care providers, schools and child care providers will be strengthened and new partnerships developed to promote current treatment and management of asthma. This would provide opportunities for public health, schools and community organizations to develop a comprehensive asthma plan including an evaluation and surveillance system. The plan would address care coordination services for children with asthma and their families; diagnosis, treatment, and avoidance of asthma triggers, and reduction of morbidity and mortality due to asthma.
Provide awareness and education programs for child care providers and early childhood school personnel to further knowledge of prevention, causes and risks.
Continue collaboration with the American Lung Association and the Department of Education to provide Indoor Air Quality for Schools-Managing Asthma in the School Environment training for all elementary school staff and nurses.
Provide educational material and literature to health care providers, community partners and families.
Seek funding to expand these activities to include a family / provider survey, morbidity and mortality data collection and analysis, and development of an adequate asthma surveillance system to monitor quality of care.
The MCH Program will continue to provide direct care and consultation services for children with asthma. A monthly Pulmonology Clinic is ongoing for the management of serious cases.

State Performance Measure 6: *Incidence of STD (not including HIV) during Pregnancy.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 1 | 1 | 1 | 1 | 1 |
| Annual Indicator | 0.0 | 1.7 | 0.0 | 0.0 | 0.0 |
| Numerator | 0 | 30 | 0 | 0 | 0 |
| Denominator | 1682 | 1772 | 1698 | 1610 | 1672 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 1 | 1 | 1 | 1 | |

## a. Last Year's Accomplishments

The MCH Program provided counseling to adolescents relative to behaviors and practices that put them at risk for STDs. Counseling was coordinated with the STD Clinic, community health centers and the Family Planning Program.
Prenatal clients in whom an STD was suspected were referred to the STD Clinic for further testing and treatment.
The MCH Program collaborated with the STD and Family Planning Programs to increase the numbers of patients screened for STDs, including chlamydia.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

See discussion under NPM #8, 15 and 18.

## c. Plan for the Coming Year

The MCH and Family Planning Programs will provide counseling to adolescents relative to behaviors and practices that put them at risk for STDs. Consistent messages will be given by the STD Clinic, community health centers, Abstinence Education Program and the Family Planning Program.
Clients in whom an STD is suspected will be referred to the STD Clinic for further testing and treatment.
The MCH Program will continue to work with the STD and Family Planning Programs to increase the numbers of patients screened for STDs, including chlamydia.
Provide data collection methods for accurate reporting of STD incidence during pregnancy.
School based health services will provide STD testing, counseling and referral for treatment.

State Performance Measure 7: *The percent of teen mothers who received parenting skills training.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 75 | 76 | 77 | 77 |
| Annual Indicator | 0.0 | 0.0 | 0.0 | 93.3 | 53.0 |
| Numerator | 0 | 0 | 0 | 250 | 123 |
| Denominator | 276 | 272 | 255 | 268 | 232 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 80 | 80 | 80 | 80 | 80 |

**Notes - 2002**

Teenage prenatal patients are referred to parenting classes offered by Department of Human Services.

**Notes - 2003**

Denominator reflects average of three years. Numerator reflects actual number of teens receiving parenting skills and counseling from several community based agencies throughout the territory.
See narrative discussion under SPM #7.

## a. Last Year's Accomplishments

The MCH Program identified community-based agencies and programs within the Department of Human Services providing parenting skills training to which DOH clients could be referred.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Department of Education offers Life Skills which include parenting on the junior and senior high school level. The Family Planning Program includes parenting skills in the adolescent outreach services. Department of Human Services provided parenting skills training to which DOH clients eligible for income assistance could be referred.
MCH, Community Health Centers, and Family Health Centers prenatal clinic services provide referrals for teen mothers.
Parent Empowerment classes are provided to approximately 250 parents annually in captive and voluntary audiences. Service providers include the Women's Coalition of St. Croix; Lutheran Social Services-Queen Louise Home for Children, St. Croix; The Village-V. I. Partners In Parenting-Parents As Teachers Program-Territorial; Family Resource Center, St. Thomas/St. John; University Cooperative Extension Service in conjunction with the V. I. Housing Authority-Territorial, and the V.I. Perinatal Partnership-A program of the Department of Health-MCH.

c. Plan for the Coming Year

School based health service providers will be encouraged to offer parenting skills training. This should be accomplished through partnerships with health educators, guidance counselors or individuals from other community-based organizations who provide family support services.

State Performance Measure 8: *Percent of infants diagnosed with hearing loss who are receiving appropriate early intervention services by age six months.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 95 | 95 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Annual Indicator | | | 0.4 | 15.0 | 26.7 |
| Numerator | | | 6 | 3 | 4 |
| Denominator | | | 1698 | 20 | 15 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 3 | 3 | 3 | 3 | 3 |

**Notes - 2004**

Denominator represents # of infants who did not pass initial newborn hearing screening and were referred for audiological diagnostic evaluation.

Numerator represents # receiving audiological evaluation and referred to Early Intervention Services for amplificiation and / or follow-up.

## a. Last Year's Accomplishments

The Early Hearing Detection & Intervention Project was funded by a CDC-Cooperative for a four year period beginning FY'01. The project strives to achieve the national standard of screening by one month, diagnostic evaluation by three months and enrollment into early intervention services by six months.
The availability of newborn screening technicians on daily basis including weekends and holidays has significantly increased the percent of infants who receive initial birth admission screening before discharge, and increased availability for outpatient rescreens.
An Advisory Committee was convened consisting of health care and early childhood providers, early intervention staff, community-based partners and family members. Brochures and developmental milestones posters are developed by the Resource and Education Workgroup. After review for completeness and cultural competency, they will be translated into Spanish and disseminated. A French Creole/Patois translation is being sought to assist with individuals who only speak this language. The National Center for Hearing Assessment & Management printed a limited number of brochures for dissemination.
A draft Memorandum of Agreement between the MCH & CSHCN Program and the Infants & Toddlers Program for provision of early intervention services for children identified and diagnosed with a permanent hearing loss is completed and submitted for approval. The purpose of this agreement is to clearly state the responsibilities of each agency in assuring that newborns are identified early for suspected or confirmed hearing loss and are receiving appropriate family centered intervention services.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

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|---|---|---|---|---|
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Medical home training was provided for MCH & CSHCN program staff by the University of Illinois at Chicago Division of Specialized Care for Children in January 2004. All MCH & CSHCN staff attended this training along with partners such as Birth to Three Program, Office of Special Education and community agencies. A medical home ad hoc committee was convened at the end of the training to plan, develop and implement a medical home model for the Virgin Islands.

Training and evaluation for the screening technicians is on-going. On-site evaluations are done quarterly by the Audiologist to assess screening proficiency, communication / interaction with families; compliance with confidentiality rules and equipment care.

The integrated newborn screening tracking and surveillance database was last modified and updated in July 2004. The database currently provides numbers for birth admission screening, follow-up outpatient screening and audiological diagnostic reports. Aggregrate reports are also a feature of the database.

A program evaluator from the National Center for Hearing Assessment & Management (NCHAM) performed a review of the program using provider and parent satisfaction surveys and evaluating monthly reports.

c. Plan for the Coming Year

Continue to monitor and track infants identified with permanent hearing loss or impairment or have documented risk conditions for late onset of hearing loss.

By the end of the project period the focus is to achieve full implementation with accurate collection and reporting of data with a fully integrated database. Conversion of the database to SPSS is under consideration. This is anticipated to provide all the required statistical data and reports.

The final report for this year's NCHAM evaluation will assist in planning future project direction or changes required to accomplish the stated goals and objectives.

In the event that future funding is not available, a sustainability plan will have to be developed. Criteria and priorities for what could be realistically continued would be identified in order to best provide screening without additional funds.

Quarterly and annual reports will continue to be evaluated for areas that need improvement. This data will be shared with collaborating programs and providers.

## E. OTHER PROGRAM ACTIVITIES

An important part of the Medicaid Program is the Early and Periodic Diagnosis and Treatment (EPSDT) program. EPSDT is designed to provide comprehensive preventive health care services to children from birth to 21 years of age. It also assures that treatment will be provided for problems and conditions identified during screening covered by MAP. The MCH & CSHCN Program is responsible for providing the medical component. Periodicity standards are based on national recommendations for routine child health maintenance. Provision of EPSDT services is a responsibility of the MCH & CSHCN Program and delineated in the MCH-MAP Agreement.

## F. TECHNICAL ASSISTANCE

Technical Assistance [Section 509 (a)(4)]
Technical assistance is of immeasurable value in ensuring the systematic, comprehensive, and valid public health approach to needs assessment, information systems development, general systems development, and special issues.
New and emerging issues in the delivery of health care to the maternal and child health population demand on-going staff training and education in order to continue to provide current and adequate comprehensive, culturally competent services.
The geographical location of the territory and the high costs of travel to the mainland are barriers to travel for training. Reassessment of staff training needs dictate that technical assistance training in the identified areas should be offered within the territory in order to maximize the benefits obtained.
See the complete Form 15 for the V.I. Technical Assistance request for FY 2005.

## V. BUDGET NARRATIVE

### A. EXPENDITURES

The request for federal funds is based on OBRA-89 regulations and program priorities. Emphasis is placed on allocating resources to ensure service availability, operational capacity, and the achievement of positive health outcomes. Specific allocations were made to support comprehensive program development and obtain needed personnel to implement the annual plan. This was done within restrictions of the Government of the Virgin Islands budgetary, financial, accounting, procurement, and personnel system. The MCH & CSHCN Program is guided by such government regulations and policies.

The budget for the MCH & CSHCN Block Grant was developed by the Director, Program Administrator and the territorial Fiscal Officer. Specific estimates were requested of program staff responsible for implementing new initiatives. The process of deriving budget estimates was based on the previous fiscal year's actual expenditures and forecasted costs based on the program plan and proposed activities. Due to the assurance role of the MCH & CSHCN Program, funds must be kept available to cover patient care costs. The Title V guideline for the use of funds was followed. (Please see Form 2, Form 3, Form 4, and Form 5).

Estimates are used in providing budget and expenditure details using actual costs for direct services provision including personnel providing services to children with special needs and sub-specialty contracts.

### B. BUDGET

The Virgin Islands Department of Health is budgeting a total of $2,855,358 for FY2006. These funds are broken down as follows:

Amount Percent
Federal Title V $1,599,698 56.0%
State $1,255,660 44.0%

There is a 30/30/10 minimum funding requirement for federal funds. A waiver of this requirement is not requested during this budget year. Of the FY2005 federal Title V allocation, the allocations are as follows:

Preventative and Primary Care for Children $479,909 (30%)
Federal Title V $479,909 (30%)
Title V Administrative Costs $159,969 (10%)

Local matching funds include an additional $100,000 for the leasing of clinic space on St. Thomas. Other federal funds amount to 200,000 for the State Systems Development Initiative and Emergency Medical Services for Children. The MCH & CSHCN Program in the V.I. does not receive its program income for operating expenses. Clinic revenues are deposited into the Health Revolving Fund.

Funds will pay for personnel costs attributable to program administration for the federally budgeted positions of MCH & CSHCN Assistant Director, Program Administrator and the Fiscal Officer. These funds will also pay for inter-island travel, training, maintenance of office equipment, administrative office space, and utilities required for the appropriate administration of the program. Funds will be utilized to maintain clean and healthy facilities for all employees and consumers to enter and receive services.

Administrative costs up to 10 percent of the federal allocation will be used to support administrative staff salaries, newspaper announcements, travel for required meetings and conferences both inter-island and on the mainland, office and computer supplies, mailing, internet and postage and AMCHP annual membership dues.

Direct and Enabling Services

Funds will be used to provide preventive and primary care services to women of reproductive age and

their infants up to one year of age, children, and youth. These services include prenatal and high-risk prenatal care. These funds will pay for employment of required medical and clinic staff, pay for needed services not directly being provided by the program, pay for specialty consultation not available in the territory, provide for equipment and supplies needed by the clinics, support outreach activities and technical assistance for developing a public awareness campaign. Funds will also be used to provide inter-island travel for the Territorial Perinatologist to visit St. Croix on a weekly basis to provide clinical consultation and amniocentesis.

Funds will be used to provide or pay for services for children with special health care needs. Clinic services include screening, diagnosis and treatment provided by the following disciplines: pediatrics, nursing, social work, nutrition, audiology, speech pathology, physical and occupational therapy. Funds will be used to support contractual costs to provide on-island specialty clinics in hematology, orthopedics, neurology, cardiology, pulmonology, and off-island services such as endocrinology consults, adiologic diagnostic procedures, and electroencephalogram. Hearing aides, wheelchairs, other assistive and orthotic devices may be purchased for patients as payor of last resort after all other resources are explored and exhausted..

Population Based Services
Funds will be used to pay the cost of contractual arrangement with Howard University to conduct the newborn screening; to conduct public awareness and informational projects; to fund staff for outreach programs; public health awareness campaigns and health promotions activities; provide coordination and family support services; and to pay for transportation costs for off-island patient care. Funds will be used to support the newborn hearing screening program primarily in the form of dedicated staff time to the project. Administrative costs for newborn screening will be the responsibility of the Early Hearing Detection, Intervention, Tracking & Integration Project.
Funds will be used to purchase vaccine not available through the Immunization Program including Synergist for premature infants whose families have no insurance coverage or those families with Medical Assistance but are not covered for purchase of this specialized vaccine.
Funds will be set aside to support the Dental Health Program through purchase of sealants for eligible children.

Infrastructure Building Services
Funding to support the annual meeting of the V.I. Alliance For Primary Care will be budgeted. Funds will be used to provide staff training and development necessary to ensure compliance with national performance measures. Funds will also be used for needs assessment and related activities.
Funds will be used for complete assessment of program data capacity and technology requirements in collaboration with State Systems Development Initiative. Funds will also be used to provide technology for staff participation in webcasts and teleconferences related to program activities.

Maintenance of State Effort
The Virgin Islands Department of Health assures that the level of funding for the MCH & CSHCN Program will be maintained at a level at least equal to that provided during FY=89. Such funding will be provided through direct allocation of local funds and the provision of services to the MCH & CSHCN Program by other departmental programs as in-kind contributions. For FY 2004 funds used to support the leasing of space for the MCH Clinics in St. Thomas are not included to meet the maintenance of state level requirement.

Fair Method of Allocating Funds
A fair method for allocation of Title V funds throughout the Territory has been established by the State agency responsible for the administration of MCH & CSHCN Program. Allotment of Title V funds is based on the needs assessment and is calculated according to:
-Population size served and capacity of each island district; measurements of health status indicators and other data;
-Fixed personnel cost associated with maintaining direct service provision on each island in each of the three service components;
-Costs associated with maintaining support for services in all four levels of the pyramid;

-Coordination with other initiatives and funding streams which supplement, but do not supplant, Title V mandates.

Targeting Funds of Mandated Title V Activities

Funds from the Maternal and Child Health Services Block Grant will be used only to carry out the purpose of Title V programs and activities, consistent with Section 508.

Reasonable Proportion of Funds for Section 501 Purposes

A reasonable proportion of funds will be used to carry out the purposes described in Section 501 (a)(1)(A) through (D) of the Social Security Act. The MCH & CSHCN Program provides direct services in each of the related program components. All charges imposed for the provision of health services are pursuant to a public schedule of charges and adjusted to reflect the income, resources, and family size of individuals receiving the services. In determining ability to pay, a sliding fee scale is used based on the 2001 Federal Poverty Income Guidelines. Low income is defined as 200% of the federal poverty level or below.

## VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

## X. APPENDICES AND STATE SUPPORTING DOCUMENTS

### A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

### B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

### C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

### D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.